STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER (OIC)
OLYMPIA, WASHINGTON

Health Care Administrative Expense Analysis
Blue Ribbon Commission Recommendation #6

Final Report

11/26/07

Washington State
Office of the
Insurance Commissioner

Mike Kreidler - *State Insurance Commissioner*

Prepared by: Thomas and Associates Consulting, LLC

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OFFICE OF INSURANCE COMMISSIONER

November 30, 2007

The Honorable Christine O. Gregoire
Governor of Washington
PO Box 40002
Olympia, Washington 98504-0002

Dear Governor Gregoire:

One of the recommendations in the final report of the Blue Ribbon Commission was to reduce health care administrative costs. Recommendation #6 directed the Insurance Commissioner's Office to provide a report to you and the Legislature, identifying key contributors to health care administrative costs and evaluating opportunities to address them.

Last session, the Blue Ribbon Commission's recommendations were enacted into law as section 17 of E2SSB 5930, and funding was provided to the Insurance Commissioner's Office for consultant services to assist in preparing the report. In May 2007, the agency began collecting background data on health care administrative expenses, and in August, we retained Thomas and Associates Consulting, LLC to lead the preparation of the report. The firm researched and analyzed administrative expenses by health plan, hospital and physicians' offices, based on a survey of approximately 438 provider organizations in the state.

The report presents important background information about the size and range of administrative expenses incurred in the finance and delivery of health care services in Washington state, and identifies several important opportunities for the various parties in health care finance and delivery systems to work together to achieve greater administrative efficiency and reduced administrative expenses. The analysis builds from the work of the Washington Healthcare Forum and from the experience and achievements of the Utah Health Information Network.

I support the recommendations in this report, and hope it will initiate a new dialogue and common effort to address the challenges identified in the report. I, for one, intend to pursue further discussions with those affected by the report to explore the opportunities it recommends for achieving significant efficiencies and lowering health care administrative costs.

If you have any questions regarding this report, please feel free to contact me at (360) 725-7100.

Sincerely,

Mike Kreidler
Insurance Commissioner

cc: Blue Ribbon Commission members

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Executive Summary:

This report has been prepared by Thomas & Associates Consulting, LLC at the request and under the direction of the Washington State Office of the Insurance Commissioner.

In January 2007 the Washington State Blue Ribbon Commission issued its landmark report on health care costs and access. The Blue Ribbon Commission report included a recommendation on the subject of health care administrative expenses. In the report the commission said ***"Patients and purchasers of health care should be assured that we are using our limited health care resources in ways that truly improve the health of the population. Any dollar spent on administrative overhead is a dollar not available for patient care."***

With the spirit of improvement in mind, the Washington State Legislature passed and Governor Gregoire signed Senate Bill 5930, which included a section that directed the Office of the Insurance Commissioner (OIC) study the subject and provide a report that identifies the key contributors to health care administrative costs and evaluates opportunities to address them. This report has been prepared in response to this legislative requirement[1].

After our research and analysis, we believe that in Washington State approximately $.30 of every dollar received by hospitals and doctors' offices is consumed by the administrative expenses of the health plans and the providers. Before the doctors and hospitals receive the funds for delivering the care, approximately 14 percent of the insurance premium has already been consumed by health plan administration. The insurer's portion of expense totals approximately $450 per insurance member per year in Washington State.

We believe that these are conservative estimates and many have argued that the problem is more deeply rooted than this. Some believe and have convincing arguments that approximately 50% of all the health care dollars are consumed by administration. It is important to note that some of this expense is necessary, useful, and unavoidable - but a significant portion is in fact consumed by less than efficient processes.

In this report we review the overall administrative expenses by health plan, by hospital, and by physician offices. We focus on one of the most costly areas which involve the fragmented and complex interactions between providers and health plans. Our analysis indicates that approximately 13.5 percent of every dollar received by a physician office is devoted to health plan-provider interaction and in addition the physicians themselves spend up to 2+ hours per day working

[1] SB5930, Washington State Legislature, 2007-08.
http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5930&year=2007

on health plan related administrative work. Similarly, hospitals spend approximately 6.6% of their revenue on the health plan-hospital interactions.

Between 1997 and 2005, billing and insurance related costs for hospitals in Washington grew at an average pace of 19.0% per year. These costs do not account for the health plan side of the interaction which is in addition to what the doctors and hospitals have spent. We believe the greatest opportunity for improved efficiency and administrative cost reduction involves standardizing and streamlining activities between the providers and the payers.

To understand how Washington State can improve the administrative efficiency we looked at what others are doing and worked with medical professionals, health plans, and collaborative organizations in Washington State. We also found an interesting example of administrative efficiency in Utah and profiled the Utah Health Information Network (UHIN). UHIN has been successful in getting significant administrative efficiencies for their state. In fact the Executive Director of UHIN stated that for 3 years in a row the carriers in Utah did not raise their rates and they have told him it was partially because of the increased efficiencies that the market was achieving because of UHIN.

To find out more about the administrative costs in Washington, we conducted a survey and received substantial input from approximately 438 provider organizations. They told us that the following areas are in serious need of increased focus and improvement.

1. Claim adjudication edits/payment policies and the use of codes need to be standardized.
2. Enhanced eligibility and benefits information needs to be available on-line.
3. Better information and systems are needed for collecting the patient cost share at the point of service.
4. Notification requirements for care plans, referrals, and documentation need to be streamlined and standardized.
5. A single on-line, streamlined credentialing approach should be established for both plans and hospitals.
6. Electronic remittance advice, posting, and payment reconciliation.
7. Common forms and a single set of administrative “rules”.

Perhaps our most important observation has been that a technological solution is not a panacea. Rather we first need to focus the providers and the health plans on common business approaches in the areas noted above. Then we can use technological solutions to implement the streamlined and standardized business rules. We firmly believe that to pursue such a focused discussion we need a “venue” and significant organizational commitment to focus on the key areas that must be simplified.

Washington State is fortunate that the Washington Healthcare Forum has in fact been working on some of these issues and has created a workgroup that has achieved a modicum of success in several administrative areas. This workgroup has addressed several specific areas of administrative process improvement; however the adoption of their ideas seems to be limited.

Our overall recommendations are summarized as follows:

- Implement UHIN lessons with existing collaborative organizations, e.g. the Washington Healthcare Forum. The State should not create a new "venue" for administrative simplification and needs to work with private organizations to ensure adoption. It should appoint an existing community-based organization to be the lead sponsor for each improvement effort and should ensure proposed solutions are responsive to the needs identified in the charter for the appointed work group.
- Focus improvement efforts on a specified list of meaningful issues to address -- "top 10 improvement areas". Create a process to evaluate improvements and adopt new focus areas over time. The process to identify the most important areas must include participation from smaller provider offices which deliver a bulk of the care to the citizens of the State.
- Simplify, standardize and streamline the underlying payment rules and payment processes. Claims related administration seems to be the most common area of concern among providers and a major source of all administrative expense and frustration. Much of this is attributable to the tremendous variation that is prevalent in the various insurer rules. Technological solutions should only be considered once these business issues are resolved.
- Provide regulatory endorsement, improved communication, and increased regulatory involvement with existing collaborative organizations.
- Examine the statutory authority and process to promulgate community based "best practices/standards" into State administrative rules when necessary. Be careful not to stifle/slow down the existing dialogue and processes. We also need to better understand how such State administrative rules and subsequent compliance efforts could be structured so as to also apply to Providers.
- Work on a longer term plan to integrate the clinical and administrative policies and technical routing hubs that are being designed and implemented within Washington State.

In addition to these recommendations we have suggested that the Insurance Commissioner work closely with several stakeholder organizations to create a dialogue focused on understanding, refining and implementing these recommendations. The Commissioner and several stakeholder organizations have expressed an interest in having these types of discussions.

Project objectives:

The Office of Insurance Commissioner, as requested by the Legislature and the Blue Ribbon Commission, has conducted a study on health care administrative costs in Washington State, collaborating with providers, carriers, state agencies, the Washington Healthcare Forum, (via OneHealthPort), and other organizations. This report is the work product for this legislative study.

As stated in the OIC's request for information which initiated this project, there are essentially four primary objectives. These objectives are briefly described below:

1. **UHIN comparison and analysis** -- Create a UHIN (Utah Health Information Network) profile and compare UHIN to Washington State based activities, and examine UHIN's applicability to this State.
2. **Inventory of Innovations** - Assess the administrative costs and causes that are prevalent in Washington State. Create an inventory of improvement activities and organizations that are addressing the administrative burden of health insurance in this State.
3. **Areas of Priority** - Provide policy level guidance and recommendations on key steps and focus areas which should be a priority for reducing the administrative burdens and costs illuminated by this study.
4. **Provide policy makers background data** on the various components and definition of the administrative expenses and an overview of the magnitude of these expenses in Washington State.

These basic project objectives are further described below:

UHIN comparison and analysis:

UHIN was discussed during the Blue Ribbon Commission proceedings and the OIC asked that we study the potential of Washington State implementing a system similar to Utah's Health Information Network (UHIN). The UHIN analysis in this report examines the following:

- An overview of UHIN's history, achievements, activities, and key success factors.
- Evaluates the potential for reducing Washington State provider claims processing costs and workload through the implementation of a claims processing system similar to the Utah Health Information Network (UHIN) in Washington State.
- Describes and compares typical doctor office, or other health care provider claims processing workload under UHIN to the claims processing workload experienced by typical doctors and other health care providers in Washington State.

- Analyzes and describes the savings that could be achieved, the transition costs that would be incurred, and operational challenges that would be involved with establishing a UHIN-type organization and claims processing framework in Washington State.

Inventory of innovations:

To better understand the nature and magnitude of Washington State administrative expenses we investigated the types of administrative issues that providers face. In addition, we identified and summarized the administrative simplification activities that other Washington based organizations have already been pursuing. We briefly assessed the impact of, and degree of participation in, these improvement efforts. Specifically this "inventory analysis" addresses the following:

- Collect and analyze information that described the types and magnitude of administrative burdens that the industry currently faces while administering health insurance benefits.
- Collect, analyze, and summarize information regarding recent and current health care administrative simplification initiatives in Washington State, including information regarding initiatives of the Washington Health Forum, OneHealthPort, the Puget Sound Health Alliance, and other similarly situated organizations.

Areas of priority:

Once the UHIN profile and the background information were collected and analyzed we assessed potential priorities and drafted several strategic recommendations. It is important to note that the project objective was not to create detailed and exhaustive recommendations but rather to create a "strategic" roadmap for how to improve the administrative efficiency in Washington State. We specifically considered the following:

- Identify, analyze and make recommendations regarding future opportunities for reducing administrative expenses.
- Work with the Washington Healthcare Forum, the Washington State Medical Association, and other interested persons or entities to explore ideas for improvement.
- Identify specific opportunities for administrative simplification that could be achieved through changes to state statutes or by state agency action.

In addition to these tangible project objectives and deliverables the OIC directed that the project also identify sources of background information regarding the key components of health care administrative expenses that may provide a useful context on the issues for policy makers. We have included background data for three key segments of the industry -- insurance carriers, hospitals, and physician offices.

Project methodologies and data sources

The following describes the approach that was used to develop the project and analyze the issues described in the body of this report. The project approach was developed with and supervised by Pete Cutler, the OIC Deputy Commissioner for Policy. George Xu, Ph.D., Senior Health Economist for the OIC provided considerable analytic support and developed most of the financial data included in this report.

RFQQ and Consultant background

In July of 2007 the OIC distributed a Request for Qualifications and Quotations to retain a consultant with significant experience in the health care industry and specifically with relevant experience in the area of health care administrative business processes and technology innovation. Several consultants responded to the RFQQ and after evaluation and consideration; the agency awarded the contract to Thomas & Associates Consulting, LLC and its principle consultant Howard Thomas.

Mr. Thomas has many years of direct experience with the Washington State health care industry and has substantial experience working with the local and national carriers, the local provider community and various intermediary organizations and health care information technology firms. Additionally, he has been a strategic consultant to the provider community in the areas of business process development, IT innovation, and strategic planning. He has also provided substantial IT development support to organizations such as the Washington Healthcare Forum, Health Care Authority, OneHealthPort, and the Puget Sound Health Alliance. Mr. Thomas is an Industrial Engineer with a Masters in Business Administration and has worked in these areas for over 15 years.

Provider survey

As part of the widespread data gathering effort for the project we conducted a web based survey reaching many Washington provider organizations. The survey was distributed directly to provider organizations and also promoted by organizations such as OneHealthPort, The Puget Sound Health Alliance (PSHA), Washington State Medical Association (WSMA), Washington State Medical Group Alliance (WSMGA), and the Washington State Hospital Association (WSHA). After a 3 week distribution we received approximately 438 responses to our structured survey questions and many hundreds of detailed and specific ideas and concerns about the status of health care administration. We were impressed with the enthusiasm and content received.

One-on-one reviews
As we analyzed the survey data and other industry research that was gathered we had additional questions and found it useful to discuss solution oriented ideas with many in the industry. We conducted numerous additional interviews and meetings with physician group executives, WSMA leadership, the Uniform Medical Plan (UMP) technical advisory group, insurers, hospitals, and intermediary companies. We also reviewed our findings and results with the OIC executives on several occasions. Lastly, we had several discussions about the issues, the innovations, and future options with the leadership of OneHealthPort who has recently been supervising the work of the Washington Healthcare Forum's Administrative Simplification Workgroup. These one-on-one discussions helped the consultant to better understand the underlying issues and aided the thinking about possible solutions.

Analysis of UHIN capabilities
During our research we found that much has been written about UHIN and this information was subsequently verified. We contacted the Utah Department of Health to better understand the cost of care analyses in that state, and had multiple discussions with the UHIN technical team, and the UHIN executive team. These individuals were very forthcoming with information, their future plans and insights into the administrative situation we currently face.

Evaluation of external data, MGMA Cost reports, Department of Health Data, NAIC and other OIC reports.
The OIC's Senior Health Economist, George XU, Ph.D., collected a tremendous volume of data and was able to estimate the administrative expenses for plans, hospitals and physician offices. He was also able to apply other well researched studies to the situation in Washington State so that we could distill the information down into several major findings about the cost of health care administration in Washington State. Dr. Xu's expert knowledge of Department of Health data, NAIC data, insurer's OIC submissions, and his analysis of the Medical Group Management Association's cost reports aided this report greatly and forms the foundation for the health care industry background section of this report.

Health care industry background information:

Health care administration is expensive and a significant cause of frustration due to the many complexities involved. The various health care organizations and insurers in Washington State do not use a single common set of definitions for the various components of "administrative expenses" and frequently do not track them in a consistent manner. For this reason the specific definitions and exact amounts of "administrative expense" are somewhat open to interpretation and require definition.

The following facts and figures have been carefully reviewed and have general applicability to the health care industry in Washington State. Any specific provider or insurer would likely have a different set of specific facts due to their own circumstances. However this overview and these figures and averages are useful in better defining the major kinds of administrative expenses for policy makers and for the purposes of this report.

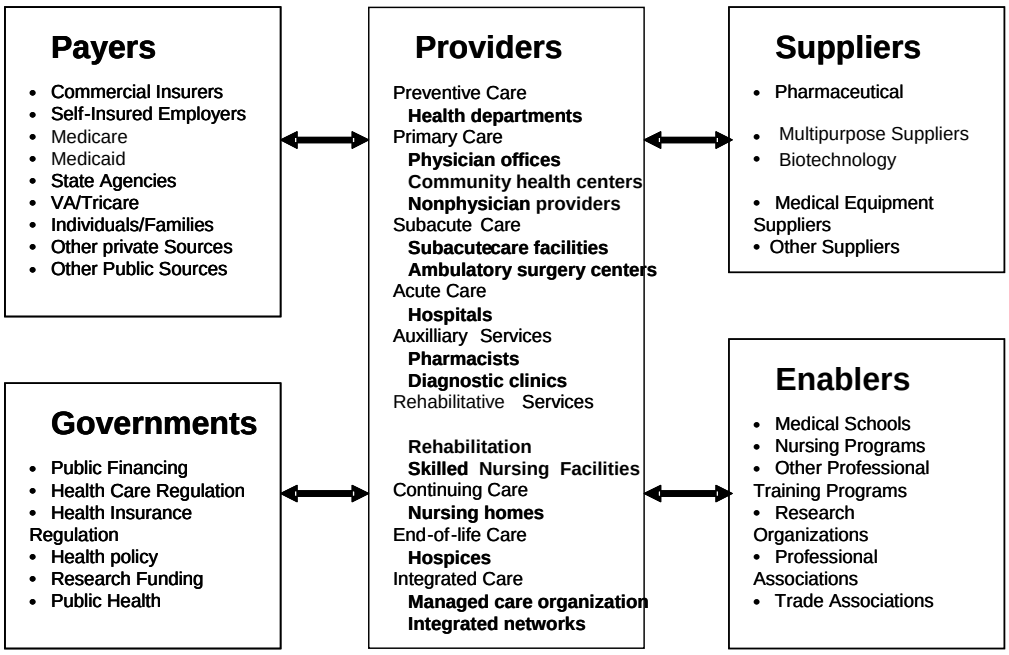
The United States has a unique system of health care delivery.

At the center of the health care delivery industry is a multitude of providers who are involved in the provision of preventive, primary, sub acute, acute, auxiliary, rehabilitative, and continuing care. Additionally there are a number of support organizations and integrated delivery networks that also span the continuum of care and may focus on various service components. There are also collaborative organizations which are also seeking to bring a higher degree of coordination, and data gathering for quality and efficiency improvement purposes.

The various system components fit together only loosely and are functionally fragmented across many different organizations. Across the web of organizations, which make up the "health care industry", there is little standardization in the core system processes. Naturally, each individual and corporate entity within this web of entrepreneurial and governmental systems seeks to manage the various financing and operating mechanisms to its own advantage, without regard to its impact on the system as a whole.

Exhibit 1 illustrates the basic components of health care delivery in the United States. Many organizations and individuals are involved in the actual delivery of health care to patients. Administration of health care services delivery involves providers and patients, medical suppliers, insurers/ payers, governments, educational and research institutions, and many others.

Exhibit 1: The complexity of the U.S. health care delivery system



The complexity in the health care industry has resulted in:

- o A large array of settings where medical services are delivered and variation in how they are organized, financed, and managed;
- o Numerous insurance sponsors which employ varied mechanisms for insuring against risk;
- o Numerous and variable incentives/controls for patients and providers;
- o Multiple payers that make their own determinations regarding how much to pay for each type of service and under what terms payment will be rendered; and
- o A multiplicity of financial arrangements that individual patients or their financial sponsors use to pay for health care services.

Health care financing variations

Health care financing in the United States is generally provided by private health care benefit sponsors, publicly sponsored benefit programs, and direct payments made by the patients themselves. These "sponsors" pay and interact with the providers directly or in many cases via an insurance company or benefits administrator.

Health insurance is a major source of health care financing and is broken into the following lines of business: small, mid and large group products; self funded groups, and individual insurance. The introduction of Medicare and Medicaid in 1965 created a large component of public financing for health care. Together these two public programs provide coverage to two groups of people outside the workplace, the elderly and the poor. Additionally, there is an ever increasing segment of the population that do not have insurance or who are under-insured and their associated bad debt places tremendous burdens on the health care systems.

This report focuses on the interactions between the Payers and the Providers and does not address the interaction or administration between Sponsors (e.g., employer groups) and Payers. The Payers include governmental agencies (Medicare and Medicaid, Basic Health, Uniform Medical Plan), health insurance carriers, and self-insured plans supported by employers or associations and usually administered by a "third party administrator" (TPA).

The figures in *exhibit 2* below describe the volume of dollars and the number of individuals involved with each of the basic distribution channels described above.

Exhibit 2: Health Care Financing in Washington State, 2006 ($million)

	Expenditure		Enrollment	
	$Million	Percent	Enrollee	Percent
Privately Financed Plans	$19,395	53.4%	3,499,748	57.0%
Commercial Health Insurance Plans	*$6,063*	*16.7%*	*1,782,345*	*29.0%*
Individual	**$537**	**1.5%**	**232,365**	**3.8%**
Small Group	**$988**	**2.7%**	**298,812**	**4.9%**
Large Group	**$3,790**	**10.4%**	**1,024,761**	**16.7%**
Medicare Supplemental	**$196**	**0.5%**	**223,304**	**3.6%**
Dental/Vision Only Plans	**$505**	**1.4%**		**0.0%**
WSHIP	**$46**	**0.1%**	**3,103**	**0.1%**
Employer/Association Self Funded Plans	*$7,601*	*20.9%*	*1,717,403*	*28.0%*
Out of Pocket	*$5,730*	*15.8%*		
Publicly Financed Programs	$16,941	46.6%	2,637,673	43.0%
Medicare	**$6,382**	**17.6%**	**845,500**	**13.8%**
Medicaid	**$3,472**	**9.6%**	**739,958**	**12.1%**
Basic Health Plan	**$238**	**0.7%**	**100,444**	**1.6%**
PEBB	**$1,118**	**3.1%**	**318,341**	**5.2%**
Fed. Employees Health Benefit Plans	**$667**	**1.8%**	**223,304**	**3.6%**
VA/TriCare/Military Programs	**$5,065**	**13.9%**	**410,126**	**6.7%**
State Total	$36,336	100%	6,137,421	100%

Source: Office of Insurance Commissioner

Note 1: Some individuals enroll in more than one plan so the number of total enrollees is not equal to the number of total insured residents.

Each of these types of payers offers different health benefit policies that have different benefits, financing rules and other administrative requirements that introduce complexities into the system. These complexities are either driven by the benefit sponsor or are internal to the payer. Another major source of administrative complexity involves consumers who also finance a portion of their health care through co-insurance, co-pays, deductibles, or through direct payment for services. The U.S. health care financing system is fragmented and is characterized by multiple payers, and many different payment sources and payment mechanisms.

Payment mechanisms

A costly aspect of this country's fragmented approach to financing health care is the complexity and multiplicity of payment mechanisms managed by the "Payers" (insurers, administrators, and government programs).

Physicians and other health care professionals are generally paid by the Payer using one of three basic payment methods: fee-for-service, capitation, or salary based compensation.

Most provider organizations in Washington State are paid with the fee-for-service approach and even this method varies considerably by Payer. Also, providers are paid by more than one method and from more than one source for the same patient encounter. A few of the payment complexities are listed below:

- variation among payer claim processing approaches and payment rules;
- payment methods and allowable benefits depend on the patient's insurance product and current eligibility for a specific service;
- variation in payment may be based on participation in care coordination and payer approval processes;
- coordination among several different third party payers, each using a different payment administrative methods; and
- collection of a variable portion directly from the patient and coordination of this payment with their insurer (deductable, coinsurance, co-pay, eligibility for a public program, etc.).

A more detailed description of the payment methods that are commonly used is available in Attachment 1 at the end of this report.

Administrative complexity in health care financing

The complexity created by the fragmented systems, and the various payment methods tends to increase health care administrative activities and costs. This has resulted in a significant and burdensome administrative cost structure for our

health care system. There are no easy answers to this problem which has developed over many years. Currently we face duplicative information systems, multiple payments methods, different systems of administrative codes and an increasing cost burden on the health care system.

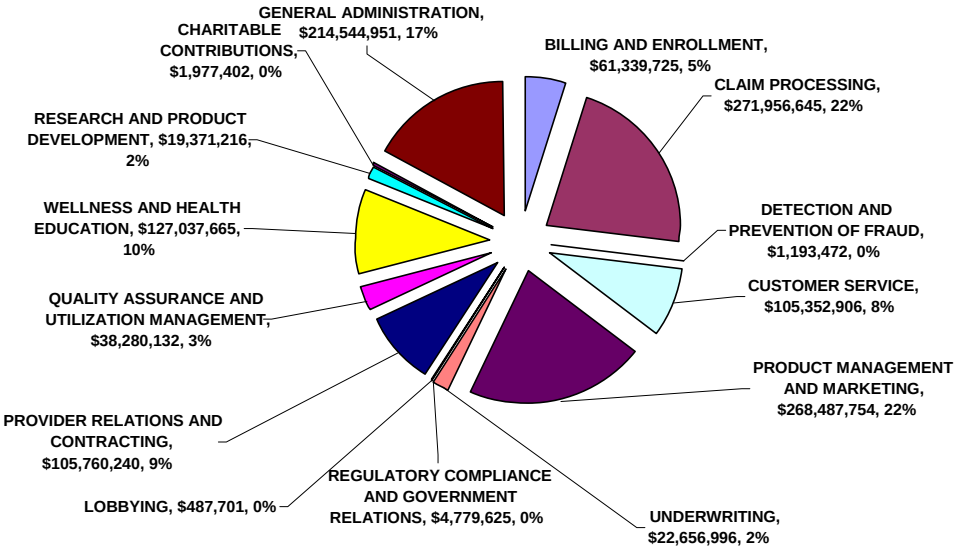
The following facts and figures provide a good overview of how much this complexity costs our system and the costs are described for insurers, hospitals and physician offices. This analysis is not to be considered exhaustive; rather it attempts to provide an overview and the basic magnitude of the administrative costs.

Health insurer administrative expenses

Health insurance carriers which operate in Washington State are required to report to the National Association of Insurance Commissioners (NAIC) and the Office of insurance Commissioner (OIC). The following analyses of administrative costs were compiled by the OIC staff and are from the carriers' financial statements and filings with the NAIC and the OIC.

In 2006, administrative expenses of all insurance carriers amounted to $1.2 billion dollars in Washington State. This is equivalent to 14.1 percent of the carriers' total earned premium and 13.3 percent of the carriers' total revenue. *Exhibit 3* shows the estimated distribution of the administrative expense by function, for Washington's health insurance carriers. A detailed explanation of the various administrative functions for insurers is available in Attachment 2 at the end of this report.

Exhibit 3: Insurer distribution of Administrative Cost, Washington 2006
Total: 1,243 Million Dollars



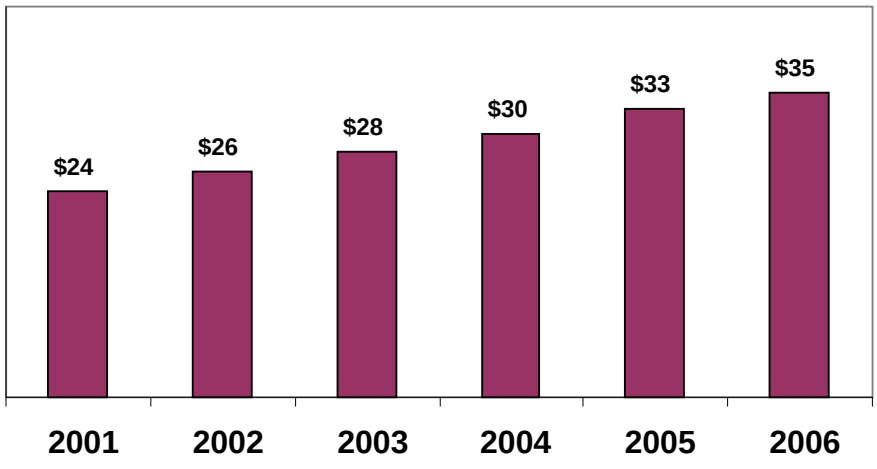
Source: Office of Insurance Commissioner 2007

Trend of Insurer Administrative Costs (2001 – 2005)
The overall annual growth rate of administrative costs is 8.9 percent and some components grew much faster than others. *Exhibit 4* lists the fastest growing components of health insurance administration and their respective growth rates.

Exhibit 4: Growth of Administrative Cost Components (PMPM), Washington State (2005 vs. 2001)				
Items	2001	2005	($) Change 2001-2005	(%) Annual Growth 2001-2005
Wellness and Health Education	$0.00	$3.40	$3.40	
Provider Relation and Contracting	$1.14	$2.83	$1.69	25.5%
Detection and Prevention of Fraud	$0.02	$0.03	$0.01	13.6%
General Administration	$3.73	$5.74	$2.01	11.4%
Regulatory Compliance and Government relation	$0.10	$0.13	$0.03	6.0%
Product Management and Marketing	$5.76	$7.18	$1.42	5.6%
Customer Services	$2.31	$2.82	$0.50	5.1%
Claim Processing	$6.12	$7.27	$1.16	4.4%
Billing and Enrollment	$1.57	$1.64	$0.07	1.1%
Quality Assurance and Utilization Management	$1.07	$1.02	-$0.05	-1.1%
Underwriting	$0.69	$0.61	-$0.09	-3.3%
Lobbying	$0.02	$0.01	$0.00	-4.9%
Research and Product Development	$0.84	$0.52	-$0.33	-11.5%
Charitable Contribution	$0.26	$0.05	-$0.20	-32.7%
Total Administrative Costs	$23.64	$33.25	$9.62	8.9%
Source: Office of Insurance Commissioner				

The cost for the insurers' administration has been increasing each year, as shown in *exhibit 5*. The insurers' portion of the total healthcare costs is substantial and is approximately $450 per insurance member per year.

Exhibit 5: Administrative Costs (Per Member Per Month), Washington State, 2001 - 2006



Sources: OIC and NAIC DSSPROD 1986 to 2004, compiled by Office of Insurance Commissioner.

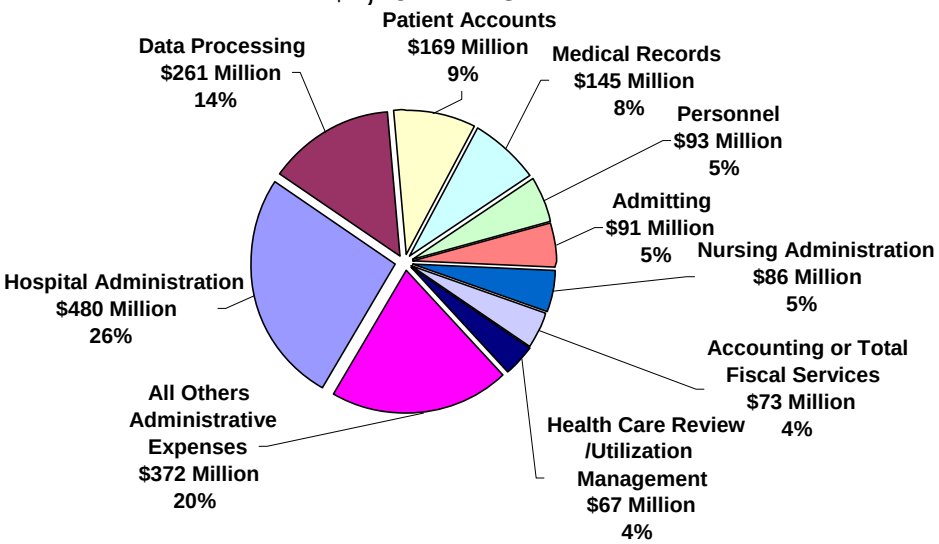
Hospital administrative expenses:

In the state of Washington the uniform accounting and reporting for hospitals began with the establishment of the Washington State Hospital Commission in 1973. The Washington State Hospital Commission Accounting and Reporting Manual for Hospitals became effective on October 1, 1974. This responsibility was subsequently transferred to Department of Health (DOH) in 1989.

We used this uniformly reported hospital financial data for 96 hospitals to analyze administrative costs of hospitals from 1997 to 2005. The data in this report was derived from financial and utilization information reported annually to the Washington State Department of Health. A detailed explanation of the various administrative functions for hospitals is available in Attachment 2 at the end of this report.

Total Administrative Expenses
In 2005, Administrative expenses of all hospitals in Washington State amounted to $2.3 billion dollars, accounting for 21.7 percent of hospitals' total expenses. *Exhibit 6* shows the distribution of administrative costs of hospitals in Washington State.

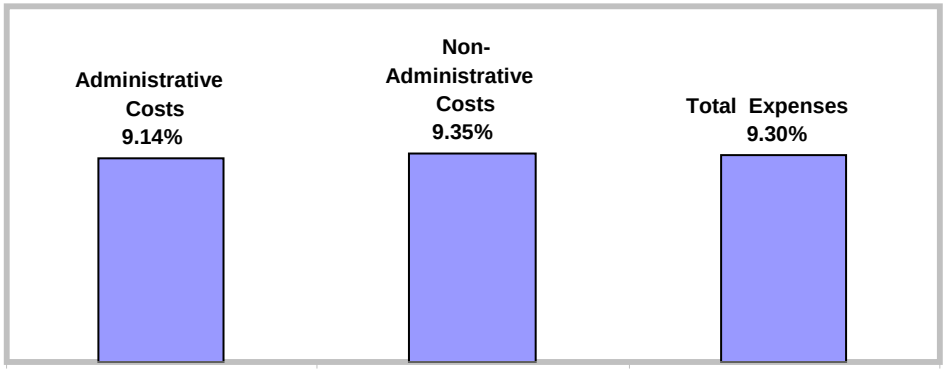
Exhibit 6: Distribution Hospital Administrative Expenses, Washington State 2005
$2,294 Million



Growth Trend of: Hospital Administrative Costs

From 1997 to 2005, the annualized growth rate of total administrative costs for hospitals was about 9.14 percent, compared to 9.30 percent for the hospitals' total expense increase. (*Exhibit 7*).

Exhibit 7: Annualized Growth by Hospital Expense Category 1997 - 2005



Source: OIC analysis of data from Department of Health

The administrative costs, as a percent of total hospital expenses, appeared stable -- 21.7 percent for 2005, compared to 22.0 percent in 1997. Over the years, the administrative costs in Washington's hospitals have grown at about the same pace as the total hospital expenses (9.1% vs. 9.3%).

Growth Rate: Components of Hospital Administration

While overall administrative expenses for Washington State hospitals grew at a pace of 9.14 percent between 1997 and 2005, some components grew much faster than others. *Exhibit 8* lists the largest components of hospital administration and their growth rates between 1997 and 2005.

Exhibit 8: Growth Rate: Ten Largest Components in Hospital Administrative Expenses, Washington State, 1997 - 2005				
Administrative Cost Items	1997	2005	1997 to 2005 Cumulative Growth	1997 to 2005 Annualized Growth
Hospital Administration*	**$179,631,438**	**$479,773,124**	**167%**	**13.1%**
Health Care Review (Utilization Mgmt)*	**$26,029,713**	**$66,670,263**	**156%**	**12.5%**
Data Processing*	**$108,753,759**	**$260,560,472**	**140%**	**11.5%**
Admitting*	**$38,248,602**	**$91,012,051**	**138%**	**11.4%**
Personnel*	**$39,101,793**	**$92,686,194**	**137%**	**11.4%**
Patient Accounts*	**$76,610,970**	**$169,025,156**	**121%**	**10.4%**
Nursing Administration*	**$44,785,330**	**$86,494,730**	**93%**	**8.6%**
Medical Records	**$79,186,124**	**$144,880,428**	**83%**	**7.8%**
Accounting / Fiscal Services	**$41,909,302**	**$73,343,531**	**75%**	**7.2%**
Other Admin Services	**$234,604,066**	**$245,656,521**	**5%**	**0.6%**
*** Growth is above average growth of total hospital spending**				
Source: Department of Health, Year-End Report for Hospitals 1997 and 2005				

While these administrative growth rates appear to be in step with overall increases in hospital administrative expenses we uncovered a troubling pattern that indicates that the fragmented financing system and the varied health payment approaches are tending to drive up the billing and insurance related administrative costs even faster than other expense items.

Billing and Insurance Related Expenses

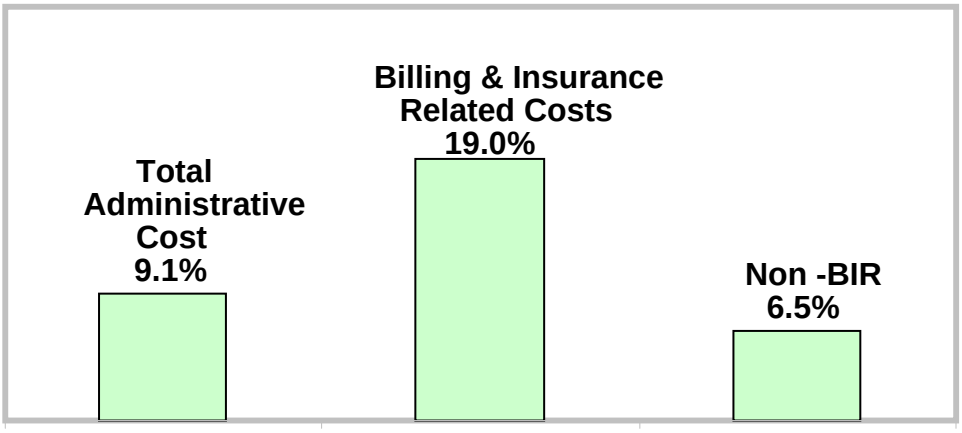
The primary purpose of billing and insurance related activities is to move money from the payer to the provider in accordance with agreed upon rules and contracts. The OIC staff estimated the "billing or insurance" related administrative activities and costs using the methodology introduced by James G. Kahn and others[2]. We applied this methodology to the list of administrative expenses listed above. Basically, the approach estimates the "billing and insurance" related costs by including portions of hospital administration, health care review / utilization management, data processing, admitting / patient accounts and personnel costs using a set of ratios provided by the research.

Based on this analysis, in 2005 the total "billing and insurance" related costs for Washington's hospitals amounted to $699 million dollars and accounted for 30.5 percent of total hospital administrative expenses. Additionally, the "billing and insurance" related costs are one of fastest growing components in hospital

[2] James G. Kahn, Richard Kronick, Mary Kreger, and David Gans. 2005. The Cost Of Health Insurance Administration in California: Estimates for Insurers, Physicians, & Hospitals. Health Affairs, Vol 44, No 6.

administrative costs. Between 1997 and 2005, billing and insurance related costs grew at an average pace of 19.0% a year, much higher than the 9.14 percent increases for the total administrative expenses (*Exhibit 9*).

Exhibit 9: Annualized Growth by Administrative Expense Category 1997 - 2005



Source: Office of Insurance Commissioner

Hospital Administrative Expense Summary

In 2005, the administrative expenses of hospitals in Washington State amounted to $2.3 billion dollars and accounted for 21.7 percent of total expenses of all hospitals. Between 1997 and 2005, total administrative expenses for hospitals grew at an annualized rate of 9.1 percent and aligned with the growth rate of all other hospital expenses in the same period – 9.3 percent.

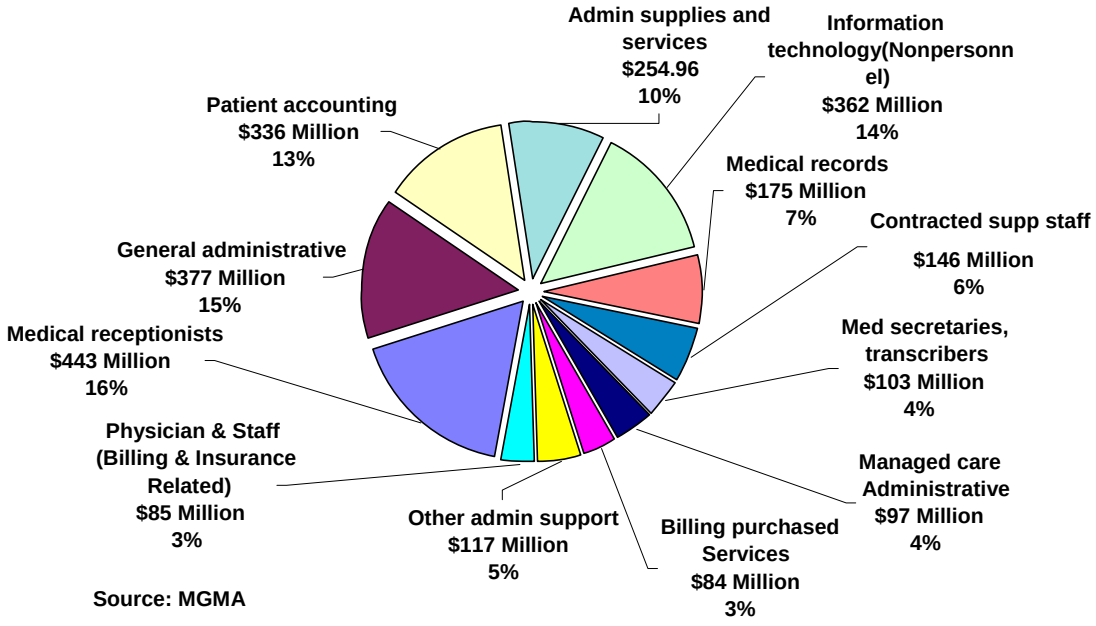
However our analysis indicates that portions of the faster growing components of administrative costs for hospitals, (Hospital administration, health care review / utilization management, data processing, admitting / patient accounts and personnel costs), are related to the billing and insurance related administration function. This portion deals primarily with money flow in the fragmented financing and payment systems and this function cost Washington hospitals $699 million dollars in 2005. This represents about 30 percent of total administrative expenses for hospitals. Additionally, according to our analysis, these costs grew at approximately 19.0 percent a year from 1997 to 2005.

Physician administrative expenses

There are no systemic financial reports for physician offices like there are for hospitals. We used self reported data from Medical Group Management Association's (MGMA) annual survey of its physician group practices. We analyzed this data to better understand the administrative costs associated with physician offices in Washington State. Due to sample size concerns, we applied data for the Western U.S. region rather than using Washington State alone. A detailed explanation of the various administrative functions for physician offices is available in Attachment 2 at the end of this report.

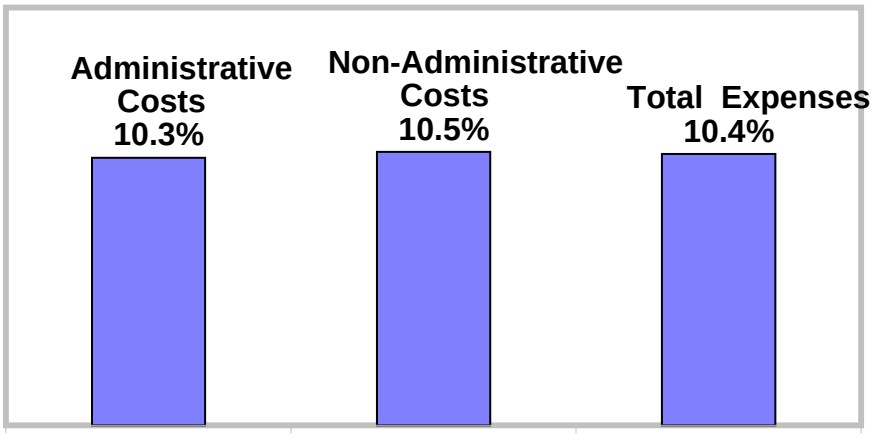
Total Administrative Expenses
In 2005, Administrative expenses of all physician offices in Washington State amounted to 2.6 billion dollars, accounting for 26.5 percent of a physician offices' total revenue. *Exhibit 10* shows the estimated distribution of administrative costs for physician offices in Washington State.

Exhibit 10: Distribution of Administrative Expenses of Physician Offices, Washington State, 2005



Trend of Growth: Administrative Costs of Physician Offices
From 2000 to 2005, the annualized growth rate of the administrative costs is about the same as the growth in total expenses for a physician's office (*Exhibit 11*). Administrative cost, as percent of total physician office expenses, appears stable at 26.5 percent for the year of 2005, compared to 26.7 percent in 2000. Over the years, the administrative costs in Washington's physician offices appear to be growing at the same pace as the total expenses of physician offices.

Exhibit 11: Growth Rates of Physician Offices' Expenses, Washington State, 2000 - 2005



Source: MGMA

Growth Rate: Components of Physician Office Administration

While overall administrative expenses for Washington State physician offices grew at an annual pace of 10.3 percent between 2000 and 2005, some components grew much faster. *Exhibit 12* lists the largest components of physician office administration and their growth rates.

Exhibit 12: Growth Rate of Administrative Cost Components, Physician Offices, Washington State, 2000 - 2005

Cost Item	2000 ($Million)	2005 ($Million)	Change 2000 to 2005	2000 - 2005 Annual Growth
Other Administration Support	$23.7	$105.6	345%	34.8%
Medical Secretaries / Transcribers	$41.6	$93.0	124%	17.5%
Medical Receptionists	$201.8	$399.7	98%	14.6%
Medical Records	$89.0	$158.1	78%	12.2%
General Administration	$195.9	$340.0	74%	11.7%
Claim Billing / Payment	$231.5	$379.2	64%	10.4%
Providers (Billing & Insurance Related)	$219.6	$333.4	52%	8.7%
Contracted Service	$89.0	$132.1	48%	8.2%
Administration Supplies & Services	$166.2	$229.7	38%	6.7%
Information Technology	$243.4	$326.5	34%	6.1%
Managed Care Administration	$71.2	$88.0	24%	4.3%
Mgmt. Fees Paid to MSO	$11.9	$0.0	-100%	-100.0%
Total Administrative Costs	**$1,584.9**	**$2,585.2**	**63%**	**10.3%**

Source: MGMA, OIC Analysis

Billing and Insurance Related Expenses

Fragmented financing and payment systems tremendously increase billing and insurance related expenses for physician offices. OIC staff estimated billing or insurance related administrative activities using the methodology introduced by James G. Kahn and others for physician offices[3]. According to this analysis, total billing and insurance related costs for physician offices in Washington State amounted to $1.3 billion dollars and accounted for 50.4 percent of the total administrative expenses in 2005. Billing and insurance related costs grew at roughly the same pace as the other administrative costs in the physician office setting. During that period, billing and insurance related costs grew at 9.5% a year, compared to 10.3 percent of total administrative expenses.

Summary of physician office administrative expenses.

In 2005, administrative expenses of physician offices in Washington State amounted to $2.6 billion dollars in total and accounted for 26.5 percent of total revenue earned by physician offices.

Between 2000 and 2005, the physician office's administrative expenses grew at an annualized rate of 10.3 percent and were similar to the average growth rate of the total expenses of the practice.

According to the analysis conducted for this project, the activities we classified as "billing and insurance" related administration are shown to cost physician offices $1.3 billion dollars per year which is roughly equivalent to 50 percent of the total administrative expenses for physicians.

[3] James G. Kahn, Richard Kronick, Mary Kreger, and David Gans. 2005. The Cost Of Health Insurance Administration in California: Estimates for Insurers, Physicians, & Hospitals. Health Affairs, Vol 44, No 6.

Administrative burdens and improvements efforts.

As described in the previous sections the interactions between providers and payers are a major source of administrative costs and are primarily due to the fragmented delivery system, the fragmented financing approaches, and the varied payment mechanisms. The costs associated with the administration of health care benefits are significant. In summary our analysis indicates the following:

Entity	Percent of medical revenue consumed by administration (% of revenue)	Admin related to "Billing and Insurance" (% of revenue)	Estimated dollars consumed by total admin in WA, 2005 (millions)
Payers	**14.1%**	**n/a**	**$ 1,243**
Hospitals	**21.7%**	**6.5%**	**$ 2,294**
Physician Offices	**26.5%**	**13.7%**	**$ 2,585**
Total	**---**	**---**	**$ 6, 122**

It is important to note that regardless of the amount of focus, effort, and improvements that we might apply to the system, a significant portion of the administrative expense will always be present and it is not likely to be significantly improved. We believe the greatest opportunity for improved efficiency and administrative cost reduction involves the administrative activities between the providers and the payers. For this reason, payer-provider interaction will be the primary focus for the remainder of this report

For the remainder this report, *health care administrative functions* include the following areas of ***payer-provider interaction***:

- health plan and hospital credentialing;
- payer contract management;
- eligibility checking and benefits determination;
- billing, re-billing, and payment dispute resolution;
- patient, secondary insurer, and third party liability collections;
- referrals and insurer notifications;
- HIPAA transactions and compliance with other governmental regulation (e.g. L&I processes, HCA/other agency reporting);
- completing forms for pharmacies and other ancillary providers; and
- reporting for clinical guidelines, quality or efficiency programs.

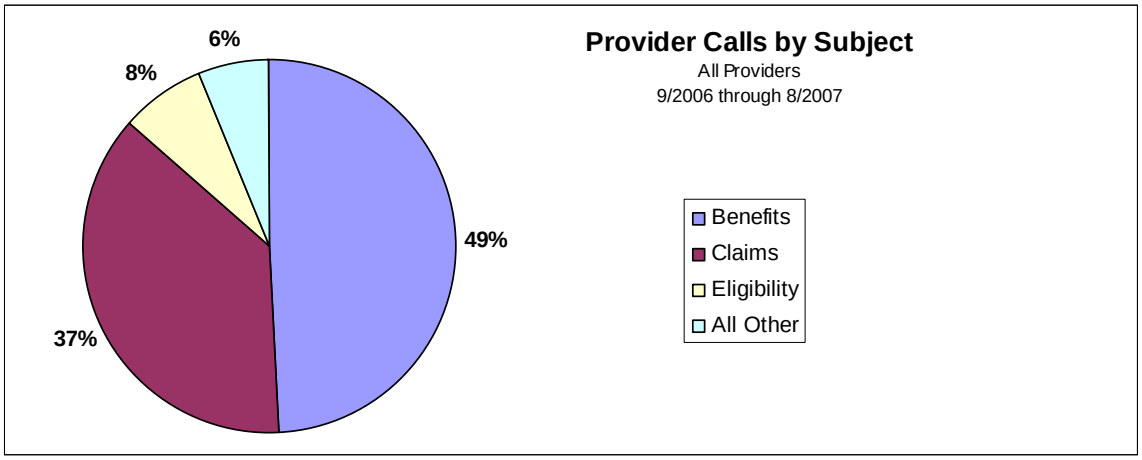
The following areas are considered *practice overhead* not necessarily related to "payer-provider interaction" and are not the subject of the balance of this report. These overhead items were briefly described in the previous portions of this report and include items such as: rent, utilities, general management of the

business, medical assistants, medical equipment, and other similar costs associated with the delivery of patient care.

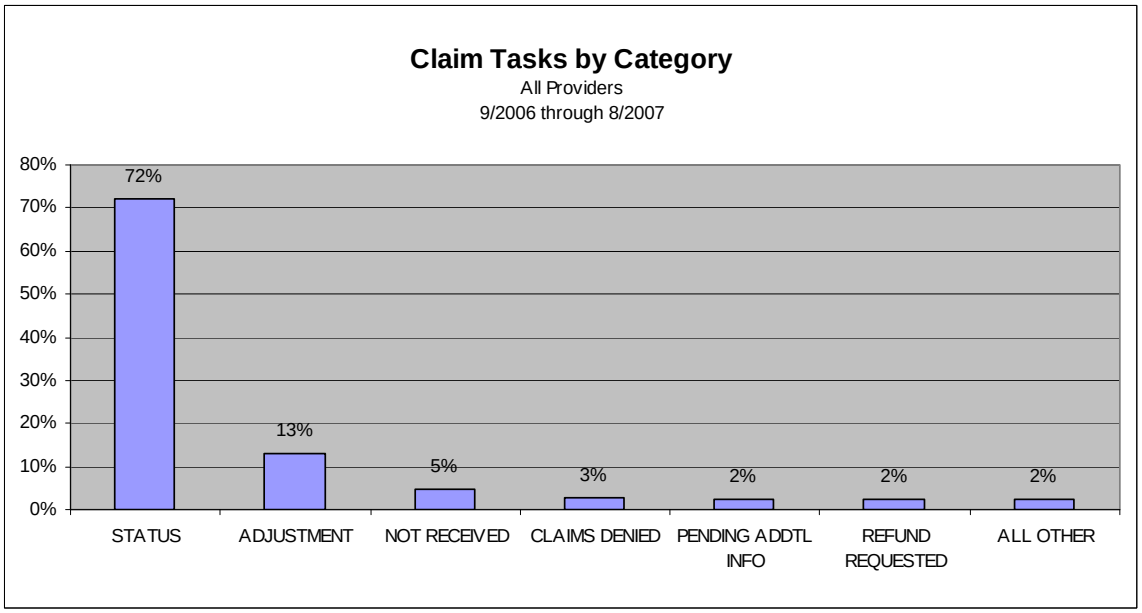
To help put these administrative activities and costs into perspective the following real life examples are provided to illustrate the provider–payer interactions:

Example #1 -- One of Washington State's largest insurers provided insightful data and discussion regarding the volume and costs associated with their provider call center:

Why do providers call the health plan?



What are the provider's "claims calls" about?



Question to the plan: *How much does it cost the plan to answer these "claims status" inquires?*

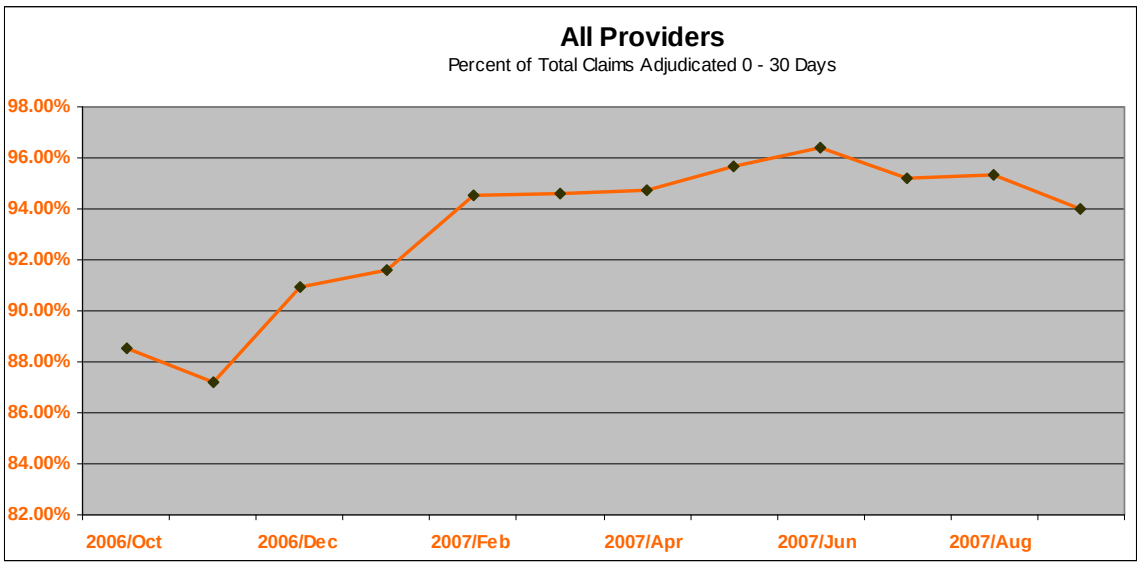
Answer - "We spend approximately $15 million a year to staff our call center"

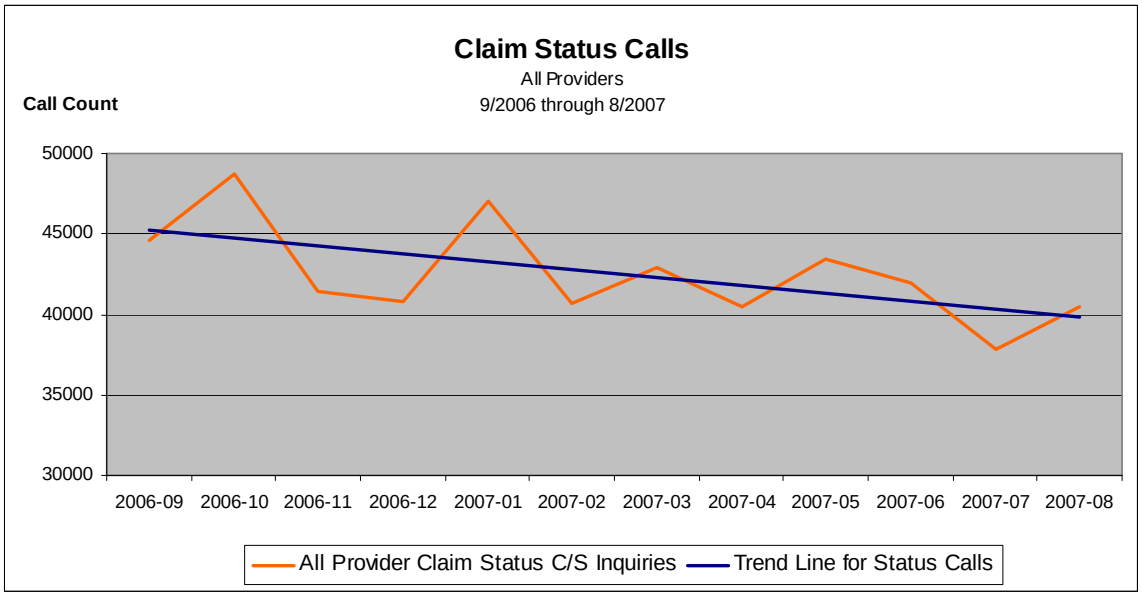
After our analysis we identified the following:

- This one plan spends approximately $4 million a year on staffing costs to answer only the claims status calls. Overhead and systems are in addition to this.
- Assuming a provider's staff spends about twice this amount of time to research the claims status, contact the plan representatives, and perform work after the call then the provider's cost of this interaction as related to this one insurer is approximately $8 million a year. Therefore, the amount expended on state-wide, plan-provider interactions for this one insurer and only for claims status is approximately $12 million per year.
- Assuming this plan has approximately 25% of the market share then in Washington State we currently spend well over $50 million per year to make calls to health plans to inquire about the status of a claim.

Question to the plan: *Many claims status calls are essentially a waste of resources for both providers and plans. How can the plan reduce these "claims status" inquires?*

Answer - "We have been working diligently to pay our claims more quickly and it seems to be slowly reducing our claim status calls. Unfortunately however some providers continue to call us for claims status no matter how quickly we process the claims." The plan provided the following charts to illustrate this point.





Therefore from this simple example we see that plans and providers must work together and develop more efficient ways of interacting to reach a mutually satisfying approach to the claims issues. It is important to note that this particular plan is known to be one of the faster paying plans and is also known to be working collaboratively with the provider community to address their interaction costs and improve their workflows. Still we are spending considerable and precious resources on this rudimentary level of administration.

Example #2 – Cost of other administrative functions for providers?
A recent study[4] by the Medical Group Management Association, "MGMA", illustrates several other costly and unnecessary administrative costs.

This study focused on a 10-physician medical practice and is likely applicable to most medical practices in Washington State. In our analysis we assumed 10 thousand physicians in Washington State, (the actual figure is closer to 14 thousand). It is important to note that these costs do not include the corresponding interaction costs for hospitals, health plans, pharmacies, etc.

- $809 per physician per year for credentialing
  - U.S. total = $485 million per year
  - WA State Total = 8 million per year
- $15,770 per physician per year for pharmacy interactions
  - U.S. total = $9.4 billion per year
  - WA State Total = $158 million per year

[4] *Source: Medical Group Management Association, Center for Research. Survey of more than 300 Group Practice Research Network members, November, 2004.*

- $3,876 per physician per year for eligibility/coverage verification:
  - U.S. total = $2.3 billion per year
  - WA State Total = $39 million per year
- $3,380 per physician per year for payer contract negotiation
  - U.S. total = $2 billion per year
  - WA State Total = $34 million per year
- $925 per physician per year for resubmitting denied claims
  - U.S. total = $555 million per year
  - WA State Total = $9.3 million per year

The costs of these administrative activities are ultimately absorbed by employers and others who purchase health insurance or pay directly for their care. These figures are conservative and do not estimate the indirect costs, e.g. physicians time to manage and respond to their own staff on these issues.

In fact, a recent facilitated discussion with the senior executives of the 20 largest physician practices in Washington State indicated that one of the most frustrating aspects of administrative complexity involves the amount of direct physician time it consumes. These physician leaders stated that most physicians spend anywhere from 2 to 4 hours per day filling out insurer forms, answering staff questions, and responding to other insurer needs as related to benefits administration. Again these inefficiencies are absorbed by those that ultimately pay for care.

Analysis of administrative issues in Washington State:

In September and October of 2007 we conducted a broad based provider survey on administrative related issues. The survey was distributed by many provider oriented organizations and we received responses from approximately 450 provider organizations. The respondents provided an excellent sampling from a cross section of our provider community. The responses came from all across the State and included large and small physician practices, large and small hospitals, alternative care providers, and ancillary care providers. The response to our survey was thorough and provided many insightful comments. The survey and the summarized results are attached at the end of this report. Below are some of the more insightful responses.

How big is the administrative burden?

As shown in prior analysis and the exhibits, the cost and complexity of health care administration is significant. In the survey we asked providers about their concern over the administrative cost burden.

- 60 percent of all the respondents reported that their administrative expenses were growing faster than most other practice expenses. 38

percent felt that administrative expenses were growing about the same as inflation;
- 57 percent of the respondents felt strongly that the current amount of administrative burden was unnecessary and wasteful;
- 63 percent of the respondents felt strongly that at the current rate of growth of administrative costs the overall system would have serious financial problems in the near future and that this situation is clearly not sustainable.

What are the top issues providers are facing?

We analyzed the administrative burdens that are currently present in the Washington health care industry. The provider survey, provider one-on-one meetings, and other studies supported the same conclusions. The following list is prioritized in order of importance to providers.

Biggest administrative issues:

- Claims payment: Understanding payment rules, getting paid accurately, getting payment mistakes corrected, understanding payment and denial codes, resubmitting denied or pended claims, and following up on unpaid claims;
- Getting authorization to provide care or submitting care related information and providing document per other insurer required notifications;
- Patient eligibility verification and getting detailed benefit information;
- Collection of patient responsibility (co-pays, deductibles, cost shares) from insured patients.

Moderately important issues:

- Posting claims payments and reconciliations in a more electronic and efficient manner;
- Process of contracting with plans and contract management;
- Completing forms, and phone calls for pharmacies and other ancillary providers to gain approval for insurance purposes;
- Providing credentialing applications and the related information to so many organizations;
- Collections from uninsured patients.

Other important findings:

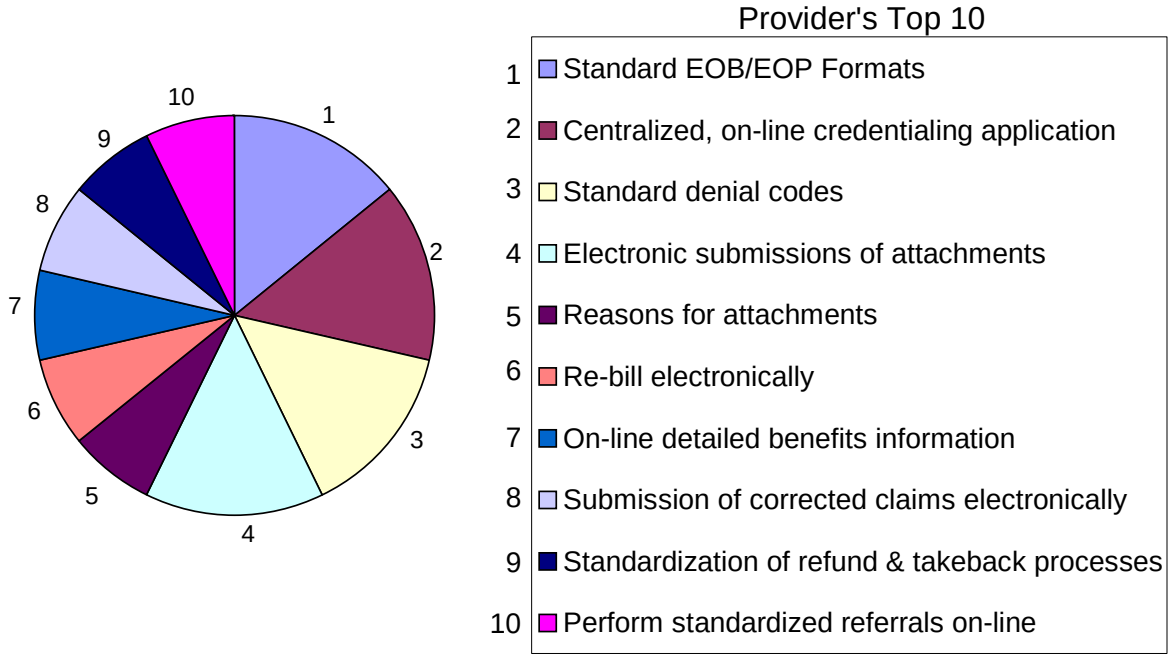
- *Claims submission.* An electronic claim costs less than a dollar to process whereas a paper based claim costs over $20 to process. Over 60% of the survey respondents reported that most of their claims were sent to the insurers by an electronic means. The gap in electronic claims is because some insurers required claims with paper attachments and in some cases the insurer is difficult to route an electronic claim. Electronic

claims submission is not perceived as a high priority item for providers and many already do this.

- In addition to these functional priorities many of the provider comments identified that the customer service of many payers is inadequate, especially as it relates to claims related concerns. Claims related concerns dominated the comments and represented over 60% of the remarks received on the survey. In fact some of the provider comments were quite cynical and expressed a view that the customer service inadequacies are purposefully designed to obfuscate the claims processing. These providers said that some insurers use their complexity and administration as a means to slow down payments or present additional hoops to aid in claim denial. It is important to note that there appeared to be a small handful of insurers that tended to garner the largest share of such complaints; others received commendation on their attempts to improve the pay-provider interactions.

A 2005 study that was completed by OneHealthPort and the Washington Health Forum's Administrative Simplification workgroup also supports the findings listed above. As you can see in *exhibit 13* this provider feedback tended to be more focused on the top issues touched upon above. This feedback provided additional validation of the issues we discovered in our research.

Exhibit 13. Providers' Top 10 Issues Aggregate results of workshop feedback from Bellevue, Mt. Vernon, Olympia, Renton, Seattle & Spokane



Washington Healthcare Forum, Administrative Simplification.

As we identified the administrative issues facing the industry we also consulted with an organization that is attempting to solve some of these administrative concerns. As far back as 2001, the Washington Healthcare Forum began organizing to address administrative simplification. The Washington Healthcare Forum is a collaborative organization involving the largest health care related businesses in Washington State. They have hired an independent consultant and workgroup facilitator and created a workgroup of volunteers for member organizations and also involved other interested parties. The workgroup has inventoried the issues they believe they can currently work on and most importantly they have provided a useful forum to bring together providers, plans and others to work on the provider-payer administrative workflows, policies, procedures, and data standards. Among other things, they have worked in the following areas:

- Developed detailed implementation guides to assist providers and plans in implementing the electronic HIPAA transactions,
- Developed and promoted claims standardization policies and common business process protocols,
- Promoted a standardized credentialing form and outlined the processes that most plans use when credentialing a new provider.
- Inventoried the variation in medical management approaches that are used by the plans and developed several common referral policies and forms.

We have reviewed their accomplishments in the context of our findings and described some of these accomplishments as an attachment at the end of this report. These areas are more fully explained on the Forum's website.

The Forum's workgroup facilitator indicated that the work necessary to develop each innovation is complex and requires a high degree of consensus. This coupled with the fact that the vast majority of provider organizations throughout the State do not directly participate in the workgroup has made the adoption of the Forum's work more difficult. The facilitator believed that the limiting factor on all of this effort is related to how quickly and efficiently the provider offices, particularly the smaller practices, can adopt the innovations and implement the necessary system changes to take advantage of the work. The provider survey echoed this sentiment;

- 50% of the survey respondents indicated that they knew of the forum's work and had used it; and
- 75% of the respondents indicated that they needed the assistance of others (health plans, IT vendors) in order to simplify their administration.

Utah Health Information Network (UHIN)

One of the major objectives of the project is to better understand the work of UHIN and compare its progress and applicability to the Washington health care environment. This section of the report is an overview and basic analysis of UHIN. Throughout this section specific areas of UHIN are compared to the situation in Washington State. The sources used for this work are listed at the end of this section. The next section of the report details the "lessons learned" from this analysis and describes how these innovative ideas could be applied to Washington State.

UHIN Overview:

⇒ UHIN was formed in 1993 as a non-profit 501(c)(6) membership based association. http://www.uhin.com/

⇒ UHIN is a broad-based coalition of Utah health care insurers, providers, and other interested parties, including State government. UHIN is a consensus-based coalition. UHIN has participation from over 90% of the State's providers and all of the insurers, labs and other larger enterprises.

⇒ UHIN members have come together for the common goal of reducing health care costs for themselves through the use of electronic data interchange (EDI). UHIN members have achieved simplification in their payer-provider administrative processes and reduced their costs significantly. Today the UHIN community is opening the door to new EDI transactions and looking into improving patient care administration and improving care quality and efficiency with new transactions and messages for clinically oriented work and the related provider-to-provider and provider-to-hospital work.

⇒ Membership participation is voluntary although compliance with certain UHIN administrative standards is required by Utah State Law once such standards are adopted by the Utah State Insurance Commissioner. An attachment listed at the end of this report provides a deeper description of what standards are required by Utah State regulations and we have analyzed how such UHIN standards generally relate to similar innovations found in Washington State.

⇒ The long range goal of UHIN is to provide the healthcare consumer with services that reduce costs and improve health care quality and access. UHIN accomplishes this by:

- creating an electronic "value-added "network to aid in the adoption and usefulness of the innovations adopted by the member organizations;
- linking community healthcare participants with a single technology based routing hub and providing a "venue" to work on common problems and common solutions;

- supporting interchange of financial and clinical information with a common technical infrastructure;
- standardize health care transactions and healthcare reporting, electronic interface development and communications services;
- gathering and providing data to a statewide data repository.

UHIN Governance:

⇒ UHIN Members are allowed to purchase a seat on the governing board for $35,000 and therefore those who are willing to pay are allowed to have a "seat at the decision table".

⇒ The board is run by consensus and much of the work appears to be done by working committees which are staffed by UHIN employees with substantial volunteer commitment from member organizations.

⇒ The UHIN Standards Committee (sub-committee to the Board) verifies all potential data standards and the consensus process can be lengthy. Thus far all standards have required a unanimous vote to pass. Once passed the standard is ratified by the full board and may subsequently become adopted by the Utah Insurance Commissioner. If adopted the standard becomes Utah State Law after a formal period of public comment and is required of the insurance companies doing business in the State. A listing of the current UHIN data standards is available on the UHIN website and also as an attachment to this report.

Market profile and comparison to Washington State:

⇒ Although both Washington and Utah are both western and relatively mountainous states they are quite different. Most of Utah's residents (93%) live in or around the Salt Lake City area (Wasatch region) and about half of the remaining residents are clustered in two different communities. The few remaining citizens live in officially designated rural or frontier areas with little access to medical care. This degree of concentration in primarily a single market is an important difference and tends to make UHIN more successful than it might be in Washington State where many different markets exist and a single organization may be more challenged in gaining consensus and making an impact.

⇒ A significant portion of the state's residents and much of the community leadership are affiliated with the Church of Latter Day Saints and as such tend to be more conforming and integrated with community based initiatives. This cultural and religious network is a notable aspect that tends to help reinforce a unified UHIN type of approach to healthcare administration.

⇒ Prior to 1993 when UHIN was being formed there was no similar type of organization that existed in Utah. Therefore at that time, the founding organizations did not have to balance their involvement between UHIN and their continuing involvement/loyalty with another similar organization which

would also compete for their attention and resources. In Washington State, most of the larger organizations that represent the critical mass in this market have already committed considerable funding and organizational commitment towards other collaborative organizations which could be construed as competing with a new UHIN-like organization. This leads us to consider how to improve upon existing efforts rather than starting something new.

⇒ The concentration of competition within the healthcare industry in Utah is similar to that found in Washington State. In Utah, healthcare and insurance services are delivered by a relatively small set of organizations which can drive a critical mass of the population. Therefore Utah, even more so than Washington and other States can set a standard with only a few parties agreeing to cooperate. Utah appears to be even more concentrated than Washington State which is surely more concentrated than other similarly sized states.

Business overview:

⇒ UHIN costs per electronic transaction are similar to those we see in Washington State. The electronic "transaction" costs are a fraction of the non-electronic, labor intensive alternatives to meeting the business needs. Utah has a higher electronic transaction rate than Washington, especially with claims status look up, enhanced eligibility lookup and electronic remittance advice.

⇒ CMS data and the Utah Department of Health reports and analysis indicate that the total cost of care in Utah is approximately 25 percent lower than that of Washington State. Unfortunately these medical expense statistics are only available in the aggregate and have not been analyzed so we can identify the root cause of Utah's lower cost of care. We believe that this positive outcome can not be fully attributed to UHIN. Conversations with those in the UHIN community have supported this finding and to date no one has been able to accurately depict the actual savings that the industry and the community have enjoyed because of UHIN. However, one interesting observation was that once the electronic transactions and common terminology and codes are in place (as is the case with UHIN) then the providers and health plans can focus their attention on improving utilization management and other cost controls and perhaps the enabling support of UHIN has aided in this more fundamental cost reduction. The UHIN Executive Director stated that the Utah insurance carriers told him that for three years they were able to hold premiums constant and that this was because of the administrative savings that UHIN had enabled.

Technical overview:

⇒ Technically UHIN acts much like a clearinghouse and routes structured messages among the participants. Data is not stored by UHIN and as a hub UHIN appears to be more of a router (post office) rather than database (warehouse). Washington State has similar clearinghouse vendors and other

technology oriented connectivity hubs, e.g. Thin, WebMD, Premera's ECC, OneHealthPort, INHS, ChartConnect, OfficeAlly, all provide similar services as that of UHIN's technology.

⇒ The key to making the UHIN routing efficient is having a centrally defined set of data standards and implementation guides so that all participants are working with the same expectation on what is included in a specific type of electronic message. In Washington State, the Washington Healthcare Forum has provided a similar venue and has been instrumental in developing several HIPAA focused implementation guides. The attachment at the end of this report compares the standards adopted by UHIN and indicates which have a similar standard promoted by the collaborative organizations in Washington State.

⇒ 100 percent of the hospitals, laboratories, local health departments and mental health centers in the state of Utah are now connected to the UHIN. An overwhelming 85 percent of commercial claims are now paid within 7 days. UHIN also connects 95 percent of the doctors and 90 percent of the chiropractors. UHIN is now beginning to work with the dental community. Our data indicates that Washington has a high penetration of providers that are affiliated with a clearinghouse. The difference between Utah and Washington is the relative usage of the different transactions and the use of standardized codes and business rules which are promulgated by UHIN.

⇒ UHIN exchanges all mandated HIPAA health care transactions. It operates as a centralized, secure network in which the transactions pass. Providers can submit electronic claims to all payers using a single standardized format. In return UHIN payers, and national payers via clearinghouses, respond with standardized electronic remittance advices. UHIN transactions are sent directly between the computers of the provider and the payer and UHIN simply acts as a hub or router. This approach is very similar to the multitude of Clearinghouses that are available in Washington State.

⇒ A listing of the current UHIN data standards and other innovations is available on the UHIN website and also as an attachment to this report. We roughly estimate that Washington has achieved approximately 60 to 70% of what UHIN has completed.

<u>Data Sources.</u>

1. UHIN website and numerous UHIN profiles which are publicly available.
2. Discussions with UHIN Executive Staff; Bart Killian & Jan Root.
3. Discussion with UHIN technology vendor, HTP CEO Ray Shealy.
4. Discussion with Utah Department of Health regarding healthcare cost analysis and data sources provided by Utah DOH.
5. State-level RHIO Development Workbook, Version 1.0, UHIN Site Report and Executive Summary
6. CMS cost of care data and reports.

Opportunities to improve Washington efficiency

After detailed review of UHIN and other simplification efforts, we believe Utah has achieved a significant level of administrative efficiency because of a few basic and fundamental enablers, in priority order:

1. UHIN created a common and single venue for all of the providers and plans to meet, discuss their priorities, and determine how they could work together to achieve administrative simplicity.
2. UHIN focused on working the business processes first and then the technology solution. A quick glance at the UHIN achievements will indicate that fully half of UHIN's accomplishments are in the form of a standard policy, a standard workflow, or a business guide to aid in implementing a new data standard.
3. UHIN provides a very useful technology platform that makes it easy for large *and* small organizations to work together to implement their agreed upon data standards.

As indicated above the common venue and organizational commitment for change must first be satisfied. Then a focused discussion about how to standardize the business policies and processes, and then the technology is applied to actually implement the commitments. If the order were reversed the simplification would not have occurred.

In Washington State we have varying aspects of each of these enablers, although we still have much to do.

Create a "venue" for dialogue and commitment

Perhaps the greatest learning for this project has been the importance of getting a focused organization in place and organizational commitment to simplifying the administration in health care. As illustrated in our background section, the healthcare "system" is actually quite fragmented and little cross organizational coordination truly exists. UHIN provided just this "venue" for Utah health care industry participants to gather and address their needs and innovations. Washington also needs a venue for administrative innovation.

In Washington there are several collaborative organizations that should be considered. The Washington Health Forum seems to be the best suited for a statewide venue. The Forum has the attention of the largest payers and providers and also the participation of the state medical and hospital associations. However, it seems that not all of the significant market areas are represented and there is a significant and noticeable absence of the smaller

provider organizations. It should be noted that smaller provider organizations actually provide the vast majority of the care for our citizens and if we fail to bring this segment of providers into the discussion then "common solutions" will not be implemented and we will fail to improve our situation.

Trying to consolidate all of the work and potential improvements into a single unified organization such as was done with UHIN does not seem to be feasible in Washington State. Additionally, the politics of such an undertaking would likely slow the existing processes of simplification. Having the State take on the direct "coordination" of the industry is not necessarily a workable solution either.

Rather than the State "being" the venue, the role of the State should be to:

- Proactively work with private organizations to identify and prioritize specific opportunities for improvement.
- Assist in identifying, cultivating and disseminating known "best practices".
- Identify and work with other "convener" organizations and aid them in getting broader participation and commitment to innovations.
- Stimulate the private enterprises to focus on the prioritized improvement areas and implement innovations that are already proven.
- Consider making certain innovations and best practices required and monitor compliance of those that choose to remain outliers.

In unique and specific simplification areas the State could at times choose to be the "convener" of individual payers and providers or could convene several different collaborative payer/provider organizations (such as OneHealthPort, Qualis, WSMA, INHS, or the Washington Healthcare Forum) so as to help to drive a broader state-wide consensus on improvement areas and specific solutions.

Another of the State's role in working with the Forum (or another "convener" appointed to address a specific area) could be to ensure that the under-represented groups are adequately involved, widespread dissemination occurs, and that non-participative payers and providers are subsequently motivated to respond to the common simplification ideas that are generated. The State must send the message that non-participation and non-standardization in priority areas is unacceptable. This is precisely why the UHIN founders invited the State to play a compulsory regulation-based role.

Use national standards to "jump start" local standards

UHIN and many others are successful because they have unified their community to speak a common administrative language and adopt specific technical solutions to efficiently route the work among the trading partners. This type of work involves technology but it is rarely a "technology" barrier that causes problems. Typically the hang ups involve fully understanding and implementing

the business rules and business processes accompanying a particular technology oriented standard.

For instance, the Washington Healthcare Forum has created a multitude of "Companion Documents" and best practices guides for the nationally mandated HIPAA transactions. These implementation guides have been very helpful to express exactly how the national HIPAA transactions are specifically applied by the trading partners in Washington State. Without these guides, which are available electronically on the Forum website, each party would have been left to decide upon a multitude of detailed configuration and business issues for each partner. This is not trivial work. An "implementation guide" for a single transaction is approximately 40 pages in length and full of detailed business and technical specifications. Unfortunately even with an implementation guide and a national standard, there still remains considerable variation in the actual meanings of various codes that are contained within the uniformly structured messages. This aspect of "unified codes" is another area where UHIN has been successful in reaching consensus and driving uniformity and efficiency. A review of several of the Forum's implementation guides was helpful to illustrate the lack of code uniformity that we currently have in Washington.

Where ever possible the industry should push for consensus on a single set of codes and their meanings. This unfortunately is not easily accomplished and in most cases this is where the reality of implementing new transactions on the older legacy IT systems defines what may be possible in the short term. Over time the legacy systems can be changed to accommodate more consistent definitions but only if the community oriented venue is present to help establish a consensus and direction on this aspect.

Adoption is the objective, "State Rules" may be a means

One of the major features we found in UHIN is the degree of private-public partnership. The UHIN community agrees to specific standards and benchmarks and then some of them are adopted into State Law. This was initially done at the request of the UHIN community and as a means to enforce wide-spread adoption and improved efficiency for all citizens. This was not pursued first by the regulators seeking an element of power over the industry.

This approach has two unique aspects that are noteworthy. First, if the community participants know that a particular standard may ultimately become part of the State Rules then the desire to participate and influence the standard becomes a much higher priority. Industry commitment and focus is vital. Second, if a community has an inwardly focused organization which will not participate or compromise for the good of the larger community then the law is the only expedient way to motivate them to change. Unfortunately, this is the reality with some of the organizations in our State (as it also was in Utah) and this regulatory "stick" has been useful to get the adoption necessary to achieve the public and private good.

However, a regulatory-based approach is not without its drawbacks and risks. If providers or plans become fearful of an overly aggressive regulator or a regulator does not truly understand the implementation details then the UHIN approach (private-public partnership) could easily backfire and the community and industry participants might spend more time and effort fighting and extending the State rule making process rather than using it for a positive purpose of increasing adoption. Therefore, any efforts to turn the administrative simplification innovations into State Law must be carefully managed to ensure they are focused on increased adoption and are being led by community efforts.

Technology is only an enabler, it is not the "cure"

It is critical that policy makers do not view the administrative issues as technology "gaps" in which an IT vendor or and IT solution can provide a cure. It is far more complex than this. The key to solving our administrative inefficiencies lie in creating more uniformity in the various payer business rules, aiding the providers to better understand and comply to a single and consistent approach and then apply these rules with an advanced technological solution.

For instance, when a provider seeks to order an MRI or diagnostic tests, each health plan has a different set of rules that must be followed for reimbursement. Some health plans also have different rules depending on the type of insurance product the patient has and in some cases who their employer is. This variation is very difficult to understand, track, and even more difficult to comply with in an efficient manner. If a provider simply does "it" one way for all of their patients, then it is an absolute guarantee that for some patients the provider will be wasting their and the insurer's resources because a prior approval is not required for this particular service and in other cases if they do not seek a prior authorization they will be denied payment for their services.

Below is a real sample of several payment policies that illustrates our point that the variation is complex and driving a substantial portion of administrative costs. These policy examples were copied from the Washington Healthcare Forum's website:

- There are many examples of clinical services that will typically be delivered by (or directly ordered by) a practitioner who is not the PCP and/or the service will be delivered in a facility other than the PCP's location. However, in most cases, the Primary Care Provider (PCP) is responsible for initiating the referral notification to the appropriate health plan. Additionally, once the PCP refers the patient to a specialist for treatment (and the health plan has received notification of this referral), additional authorization requirements differ by health plan.
  - **For Plan A and Plan B**: the specialist can submit referral requests to the health plan for diagnostic and DME services. The specialists cannot submit referral requests to other specialists and the patient must be returned to the PCP for additional treatment plans.

- **For Plan C**: the specialist can only submit a referral request for surgery or DME for a service that was referred to them by the PCP.
- **For Plan D**: the specialist can submit referral requests to the health plan for diagnostic and DME services. The specialists cannot submit referral requests to other specialists unless the PCP has indicated to the health plan that the specialist is to "assume management".

- Some services require a "referral" as a pre-requisite for payment. Some plans require a "clinical review" to ensure a specific service is necessary. Some plans require both a referral and a clinical review. Each plan has varied rules on which services must meet these various requirements. Below are a few real life samples of how these policies vary for several routine clinical services:

Procedures / Conditions	Plan A Policy	Plan B Policy	Plan C Policy	Plan D Policy
Rhinoplasty	**Preauth required**	**Not a covered benefit**	**No requirements**	**Benefit Advisory required or claims will pend for medical review**
Acupuncture	**No requirements**	**May not be a covered benefit**	**Preauth required**	**Some patients are now allowed a self-referral for a limited number of visits for acupuncture.**
Colonoscopy	**No requirements**	**No requirements**	**Pre-service review is required or claims will pend for medical review**	**Pre Auth required only for employer group ABC**
Genetic Testing	**Preauth required -- review plans medical policy and clinical review criteria for more information**	**Preauth required**	**No requirements**	**Benefit Advisory required or claims will pend for medical review**
Prostate Seed Implant	**Preauth required**	**No requirements**	**Other requirements, see plans website for details**	**Benefit Advisory required or claims will pend for medical review**

After considerable review of the variations in rules that exist for several plans we find it difficult to believe that any one plan's rules are truly superior over another's (i.e., that the rule will result in improved quality or better cost control) – they are all just different controls. Plans may feel that their rules are their "proprietary" approach and are critical to their competitive advantage. This thinking must be challenged and a deeper commitment to simplification must prevail so that

providers can truly comply with a best practice and truly deliver the most cost effective and quality care. Lastly, automating this level of variation or making it easier to discover the many permutations and conditions that apply is merely putting a band-aid on the wound and is not a sustainable solution. We must first seek a higher degree of standardization.

Top priority areas:

After considerable and widespread input on the priorities, we produced a listing of potential priority areas. These priorities were further discussed with many providers, executives, and consultants who have worked on these issues for many years. We received significant validation on the following list and now submit this as a "starter list" of priority focus areas that should be further discussed with industry leaders so as to gain a sense of commitment on each area.

1. Standardize the health plans use of the most commonly used claim adjudication edits/payment policies and standardize the use of their claim payment codes. There are several national class action suits that have provided good examples of how this could be framed. Refer to the national Love & Thomas settlements with the Blues for a good example of these issues.
2. Enhanced eligibility and benefits information on-line and in batch. Providers need to know if a patient is covered and for exactly what benefits. There are HIPAA transactions for these services but in our state less than 9% of such information is electronically transmitted, as opposed to closer to 50% in Utah where an "enhanced transaction" is in place. Improving the enhanced message coupled with more standard codes will greatly improve this area of administration.
3. Better information and systems for collecting patient cost share at the point of service. Patient cost shares and the types of cost sharing approaches are increasing. Providers can no longer just provide the service, wait on the insurer information/payment and then chase the patient for the final balance owed. Providers are suffering from spiraling patient default rates and lower/more lengthy/more costly collections. A focused effort to define acceptable processes and technology aids so that providers can efficiency collect at the point of service must be created.
4. Streamlined and standardized notification of care plans, referrals, and documentation related processes. The examples of the medical review variation in this report illustrate the problem. As insurers and employers create more methods of cost control this complexity is increasing. An inclusive process to work collaboratively with plans and providers and to only vary as an "exception" must be considered.

5. Single on-line, streamlined credentialing for both plans and hospitals. Many in Washington have adopted a standard credentialing application. This has helped this some in this administrative area. Working with the hospitals to also adopt this common format is now an important consideration. The State should also work with the industry stakeholders to examine a centralized technology solution so that a provider can update their information once and all the plans and hospitals could use this resource for their credentialing needs. This "utility-like" resource could also be useful to produce more accurate directories and be used for other communication purposes.
6. Electronic remittance advice, posting, and reconciliation. Every claim results in a computer generated form that provides the caregiver with details about how much was paid and any advisory information. HIPAA specifies a standard format for this data and it is generally available from the payers. Yet a vast majority of providers re-type this information, adding costs, increasing errors, and further delaying their other administrative duties (patient cost collection). Use and enhancement of the payers' electronic capabilities should be better exploited and any barriers to this should be addressed.
7. All payer portal (including Medicaid, Labor & Industries, and Medicare). When the Forum commissioned the creation of OneHealthPort it showed tremendous leadership to help improve the adoption of each of the payers and the hospitals independent web portals. This innovation has helpful but still electronic adoption rates are lower than most hope for. A serious dialogue about consolidating the payer's information into a single location should be undertaken. This is not a trivial area and without additional "rule" consolidation and simplification a single portal may not be possible.
8. Common forms and single set of administrative "rules". The Forum and others have adopted several standardized forms (e.g. standard referral form) however, not all payers accept these and there are numerous other forms and rules that could also be standardized and streamlined. An inventory of these forms and their rules and the barriers and approaches to standardization should be undertaken.
9. Simplify Coordination of Benefits processing (COB) and consider refining recent State Rule changes. COB processing is a relatively infrequent requirement as less than 10% of insureds has dual coverage. However, for this limited population insurers believe it is one of their most costly drivers of administration. The recent rule changes in Washington State have exacerbated this situation and are now forcing increased manual processing, requiring "estimated advance payments" which in turn are creating additional reconciliation and recovery costs and complexity. For instance one of the State's larger insurers believes that the new rules will cause approximately $1.6 million in overpayments per year which will then require additional and special administrative processes to reconcile. This situation will also cause significant rework and frustration at the practice

level because the “estimated advance payments” will cause many additional accounting entries and time consuming reconciliations. Less sophisticated providers will suffer even more. These rules should be aggressively worked by a provider/ plan collaboration so that the most efficient process can be achieved.

Summary of key findings and recommendations

As demonstrated in this report health care administration is complex and costly. We believe that approximately $.30 of every dollar is consumed by health care administration. The administrative interaction between providers and plans seems to be the most complex and costly to our overall system and is worthy of significant improvement focus. Some of this expense is necessary, useful and unavoidable. However we have considerable room for improvement.

Health plans consume approximately 14 percent of their premiums on their various administrative processes. A substantial portion of this is directly related to working with provider organizations. Approximately $450 per insured person is spent each year on insurer related costs.

Hospitals spend approximately 22 percent of their overall expenses on administration. Approximately 30% of this administrative cost is related to insurer-hospital interactions. These insurer-hospital costs are growing at approximately 19 percent per year as compared to 9 percent of all other costs.

Physician offices spend approximately 27 percent of their revenue on administration. Approximately 50% of this administrative cost is related to insurer-physician interactions. Additionally, physicians spend approximately 2 hours per day filling out insurance forms, answering staff questions and responding to other insurer oriented work that relate to benefits administration. These insurer-physician costs are growing at approximately 10 percent per year and are not sustainable.

The Utah Health information Network (UHIN) is a unique approach that has been successful in addressing the simplification needs and lowering administrative costs in Utah. UHIN per se is not the solution for Washington for many different reasons. However, the UHIN example is a very useful benchmark for Washington to consider. Specifically we need to pursue the following:

1) Create a venue for improvement efforts.
2) Focus cross organizational commitment on a few top areas and reap those benefits.
3) Simplify and standardize the business rules and underlying codes and payment policies.
4) Apply technology solutions only once the underlying business rules are standardized and streamlined.
5) Promulgate selected rules and standards into State Law and force compliance on those organizations that do not want to participate.

The Washington Healthcare Forum (via OneHealthPort) is a leading organization that is addressing administrative simplification in Washington. Increased collaboration with the State would be useful to assist in improving adoption, broadening representation and possibility aiding in regulatory compliance.

The priority areas listed in the report should be considered a starter list of areas to focus on. The State should consider "appointing" a lead collaborative organization to facilitate the development of common solutions and then aid the collaborative organizations in implementing theses approaches. The State should also help these collaborative organizations to raise their expectations, e.g., an approach that suggests automating the current level of variation should be challenged.

UHIN is evolving the use of their technology. They are using their "venue" and relationships as a catalyst to promote clinical data sharing. The enablers that aid administrative simplification are adaptable to the "health information technology" and clinical data sharing needs. Washington needs to consider longer term plans and strategies to integrate the clinical and administrative policies and technical routing hubs.

Lastly, it is important that the State government and the Industry (plans, hospitals, physicians, and other interested parties) begin a dialogue about these findings and work collaboratively to refine the recommendations and pursue an implementation approach.

Listing of Attachments:

1. ***Common payment methods***
2. ***Description of administrative functions***
3. ***Administrative Expenses Survey - Summarized Results***
4. ***Inventory of Washington Healthcare Forum Administrative Simplification accomplishments***
5. ***Listing of UHIN transactions***

Attachment 1 – Common payment methods.

Physicians and Other Health Care Professionals

Fee-for-service: Under the fee-for-service method of payment, professionals receive a fee (or payment) for each service they provide. The actual medical service is the unit of payment and there is some discretion regarding what constitutes a medical service. A service unit can be very distinct (i.e., urinalysis test) or relatively comprehensive (i.e., an appendectomy where the physician payment covers all care associated with the procedure including the preoperative visit, the surgical procedure itself, and some follow-up care). Thus, the service for which payment is made can actually be several separate, discrete services. Fee-for-service payments to professionals are based on charges that are either set by professionals or by third-party fee schedules. A fee schedule defines the maximum acceptable charge for medical services.

Capitation: The capitation method of payment provides professionals with a defined, periodic, per-patient payment (usually monthly) for every individual enrolled in insurance plan, regardless of how many individuals seek care or how much care is provided. Capitation agreements with providers specify what services are covered and those can vary considerably among agreements. The capitation payment may be based on the characteristics of individuals (such as age) enrolled in the plan. This helps compensate providers for differences in the expected use of medical care by groups of patients with similar characteristics.

Salary: The salary method of payment provides professionals with a fixed payment or salary (usually monthly or yearly) that does not vary with the number of people in the plan or the number of patients treated or the number of services provided. In the United States, this method is frequently used for non-physician professionals in a variety of the employment settings. Physicians working for government agencies, some HMOs, or large group practices may also receive payment by the salary method.

A professional can receive payment under a single payment method while third-party payers make payments for that professional's services using several different payment methods. For example, a physician belonging to a large group practice may receive a salary from the group practice while the group practice receives payments for the physician's services from third-party payers using a capitation method.

Hospitals and Other Institutional Providers

Numerous methods are used to pay for hospital services, such as payment based on established charges, retrospective costs, per-diem rates, per-case rates, capitated payments, or budgets. In United States, many different third-party payers use a broader mix of these methods.

Mechanisms Used to Pay Hospital Providers

Charge-based payments: Prevalent only in the United States, the charge-based method requires hospitals to define a price or "charge" for each hospital service. This hospital-established charge is then paid either directly by the patient or the patient's health insurance company. Under this method of payment, hospitals determine the charge. This method is not used by government payers.

Cost-based payments: The retrospective cost-based method is designed to pay the actual costs of hospital services as opposed to whatever charge hospitals may request. Under this method, a set of accounting rules defines what the hospital costs are for a defined group of patients. Although relatively common in the United States from 1966 to 1983 because it was used by the Medicare program, most state Medicare programs, and some large insurers, this method has lost importance since the mid-1980s.

Per-diem payments: Hospitals paid by the per diem method receive payments based on the number of days a patient spends in the hospital. This payment is usually not adjusted to allow for differences in patient characteristics (i.e., the same payment is paid for patients undergoing heart surgery as for maternity cases). However, per-diem payments may vary by hospital. The payment is agreed upon through negotiations between a third-party payer and a hospital.

Per-case payments: The per-case method pays hospitals a fixed payment for each patient the hospital discharges. In the most extreme form of the per-case method, the payment is the same for all patients regardless of a patient's medical condition. More commonly, patients are classified into groups based on expected costs for necessary care (known as case-mix formulations) and payment varies according to a patient's group classification. The payment may also differ for different types of hospitals (teaching hospitals, community hospitals). Per-case payment methods may contain provisions for additional payments for patients whose treatment costs are exceptionally high (called outlier payments). The Medicare program uses the per-case payment method and payment is based on a patient classification system called diagnosis-related groups.

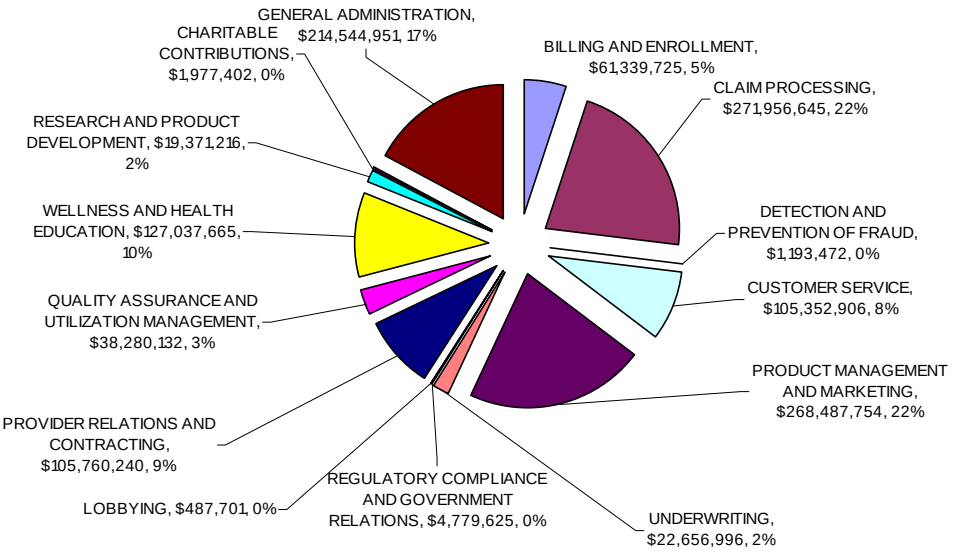
Capitation payments: Under the capitation method, the hospital receives a fixed monthly payment for person enrolled in a health plan. This payment method shifts financial risk from the third-party payer to the hospital itself and the use of this method for hospitals is relatively rare.

Budget payments: The budget method provides hospitals with a global budget or payment designed to cover all services provided by the hospital over the course of the year. The global budget may be unilaterally set by government agencies or established by formulas that account for inflation and expected changes in the size of the inpatient population or negotiated between a payer and a hospital. In some countries, global budgets account for expected differences in patient illnesses. This method is used in United States primarily for hospitals owned by the federal government.

Attachment 2 – Description of administrative functions

Insurers:

Exhibit 5: Distribution of Administrative Cost, Washington 2006
Total: 1,243 Million Dollars



Source: Office of Insurance Commissioner 2007

Billing and enrollment expenses are all costs associated with group and individual billing, member enrollment and premium collection and reconciliation functions. This may include costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card, and directory preparation and issuance, electronic data interchange expenses pertaining to billing and enrollment, and enrollment materials. Traditional expense categories that a company might allocate in whole or in part to billing and enrollment expenses include finance and information systems. In 2006, these costs amounted to 61 million dollars and account for 4.9 percent of total administrative costs.

Claim processing expenses are all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim audit function, electronic data interchange expenses pertaining to claim processing, and fraud investigation. Traditional expense categories that a company might allocate in whole or in part to claims processing expenses include information systems and legal. In 2006, these costs amounted to 272 million dollars and account for 21.9 percent of total administrative costs.

Detection and Prevention of Fraud: In 2006, these costs amounted to 1.2 million dollars and account for 0.1 percent of total administrative costs.

Customer service expenses are all costs associated with individual, group, or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. Traditional expense categories which a company might allocate in whole or in part to customer service expenses include information systems, finance, legal, and sales and marketing. In 2006, these costs amounted to 105 million dollars and account for 8.5 percent of total administrative costs.

Product management and marketing expenses are all costs associated with the management and marketing of current products. This may include costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes or additions to current products, and enrollee education regarding coverage. Traditional expense categories that a company might allocate in whole or in part to product management and marketing expenses include information systems, underwriting, legal, finance, actuarial, public relations, and network management. In 2006, these costs amounted to 268 million dollars and account for 21.6 percent of total administrative costs.

Underwriting costs are costs to underwrite health insurance policies. In 2006, these costs amounted to 23 million dollars and account for 1.8 percent of total administrative costs.

Regulatory compliance and government relations expenses are all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical, and quality reports, and administration of government programs. Traditional expense categories that a company might allocate in whole or in part to regulatory compliance and government relations expenses include information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance. In 2006, these costs amounted to 5 million dollars and account for 0.4 percent of total administrative costs.

Lobbying expenses: In 2006, these costs amounted to 0.5 million dollars and account for 0.04 percent of total administrative costs.

Provider relations and contracting expenses are all costs associated with contract negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and administration of provider capitations and settlements. Traditional expense categories that a company might allocate in whole or in part to provider relations

and contracting expenses include finance, legal, accounting, actuarial, and information systems. In 2006, these costs amounted to 106 million dollars and account for 8.5 percent of total administrative costs.

Quality assurance and utilization management expenses are all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to existing products, nurse triage and other medical care evaluation activities. Traditional expense categories that a company might allocate in whole or in part to quality assurance and utilization management expenses include information systems and legal. In 2006, these costs amounted to 38 million dollars and account for 3.1 percent of total administrative costs.

Wellness and health education expenses are all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education, and outreach services. Traditional expense categories that a company might allocate in whole or in part to wellness and health education expenses include marketing, medical services, and printing. In 2006, these costs amounted to 127 million dollars and account for 10.2 percent of total administrative costs.

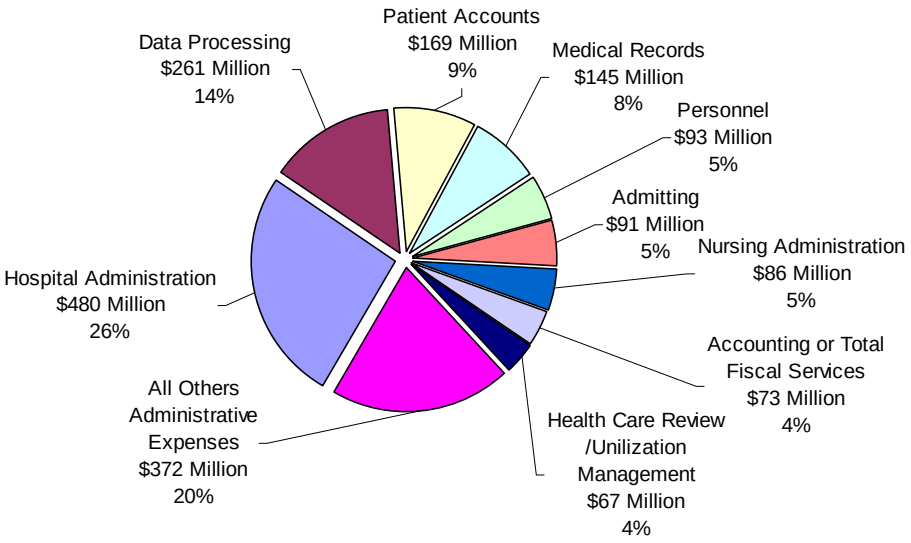
Research and product development expenses are all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, major systems development, and integrated service network development. Traditional expense categories that your company might allocate in whole or in part to research and product development expenses include actuarial, information systems, marketing, finance, underwriting, and wellness programs. In 2006, these costs amounted to 19 million dollars and account for 1.6 percent of total administrative costs.

Charitable contributions expenses are all costs related to contributions made for charitable purposes. In 2006, these costs amounted to 2 million dollars and account for 0.2 percent of total administrative costs.

General administration expenses are all costs not outlined or allocated to the other categories. Traditional expense categories that your company might allocate in whole or in part to general administration expenses include human resources, facility maintenance, payroll, general accounting, finance, executive, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations, and mail room. Taxes and assessments are not included in these costs. In 2006, these costs amounted to 215 million dollars and account for 17.3 percent of total administrative costs.

Hospitals:

Exhibit 9: Distribution Hospital Administrative Expenses, Washington State 2005
$2,294 Millions



Data Processing: Expenses used to perform the operation of the hospital's electronic data processing system, including input, storage and safeguarding of data, operating data processing equipment, data processing job scheduling, distributing output, and identifying and solving hardware and software problems. In 2005, these costs amounted to 261 million dollars and account for 14 percent of total hospital administrative costs.

Patient Account: Expenses of the processing of patient charges, including processing charges to patients' accounts, preparing insurance claims and third party billing forms, and other patient related billing activities, including cashiering, extension of credit, and collection of accounts receivable. Additional activities include interviewing patients and others relative to the extension of credit, checking references, follow-up procedures, and utilization of outside collection agencies. In 2005, these costs amounted to 169 million dollars and account for 9 percent of total hospital administrative costs.

Medical records: Expenses of Medical records include the transcription, retrieval, storage, and disposal of patient medical records; and the production of indexes, abstracts, and statistics for hospital management and medical staff uses. Additional activities include interviewing patients and others relative to the extension of credit, checking references, follow-up procedures, and utilization of outside collection agencies. In 2005, these costs amounted to 145 million dollars and account for 8 percent of total hospital administrative costs.

Admitting Expenses: Expenses of admitting patients for inpatient hospital services and the registration of patients for outpatient services. Activities include completing admission forms, scheduling admissions, and accompanying patients to rooms or service areas after admission. In 2005, these costs amounted to 91 million dollars and account for 5 percent of total hospital administrative costs.

Hospital Administration Expenses: Hospital administration performs overall management and administration of the institution. Expenses such as corporate development, financial planning, and internal audit are also included here. In 2005, these costs amounted to 480 million dollars and account for 26 percent of total hospital administrative costs.

Personnel Expenses: Activities include recruitment, employee selection, salary and wage administration, employee benefit program administration, employee health service, and procurement of temporary help (including fees paid to temporary help agencies.) In 2005, these costs amounted to 93 million dollars and account for 5 percent of total hospital administrative costs.

Health Care Review/Utilization Management: The cost center typically includes utilization review, quality assurance, infection control, risk management, professional standards review, and medical care evaluation functions. Each of these activities involves screening some aspect of patient care, analyzing patient care data, implementing corrective action when required, and monitoring care to determine whether issues have been resolved. In 2005, these costs amounted to 67 million dollars and account for 4 percent of total hospital administrative costs.

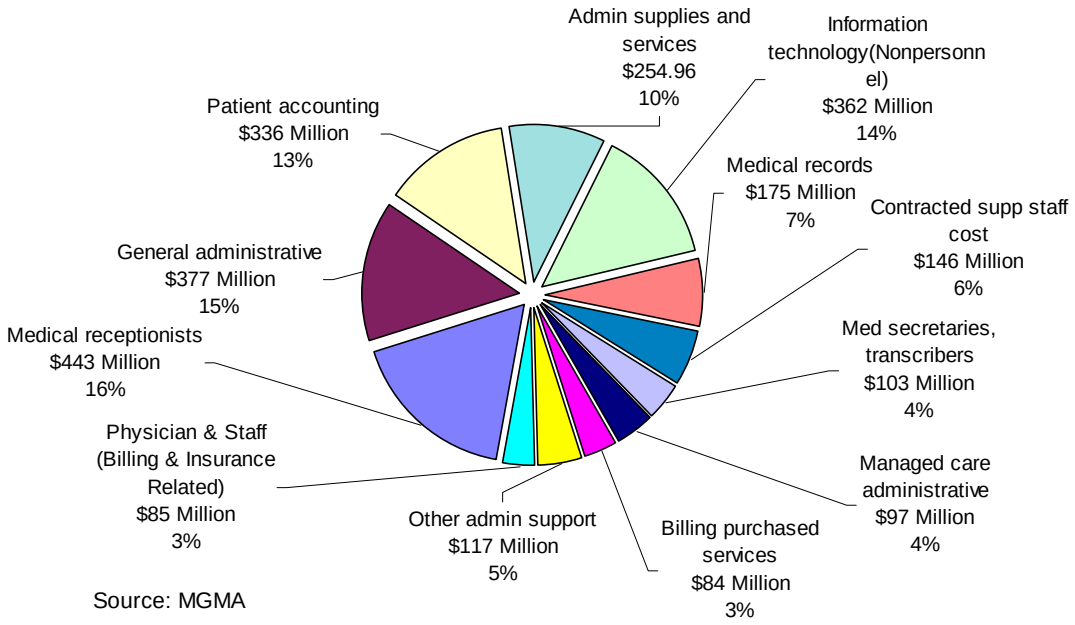
Nursing Administration: Nursing administration performs the administration and supervision of the nursing function in the hospital including scheduling and transfer of nurses among the services and units, nursing staff supervision, evaluation, and discipline. In 2005, these costs amounted to 86 million dollars and account for 5 percent of total hospital administrative costs.

Accounting/Fiscal Services: This department performs general accounting activities, including non-patient billing and accounting, of the hospital such as the preparation of ledgers, budgets, and financial reports, payroll accounting, accounts payable accounting, plant and equipment accounting, inventory accounting, non-patient accounts receivable accounting, etc. In 2005, these costs amounted to 73 million dollars and account for 4 percent of total hospital administrative costs.

All Other Administrative Costs: These costs include management engineering, medical library, community health education, public relation, employee health, and other administrative costs no included in above categories. In 2005, these costs amounted to 372 million dollars and account for 20 percent of total hospital administrative costs.

Physician Offices:

Exhibit 13: Distribution of Administrative Expenses of Physician Offices, Washington State, 2005



Source: MGMA

General Administrative Expenses: Expenses performing administrative functions and includes administrative, practice management, supporting secretaries and administrative assistants. In 2005, these costs amounted to 377 million dollars and account for 15 percent of total administrative costs.

Medical receptionists: Expenses for medical receptionists, switchboard operators, schedulers and appointment staff. In 2005, these costs amounted to 443 million dollars and account for 16 percent of total administrative costs.

Patient Accounting: Expenses associated with performing billing/accounts receivable, coding, charge entry, insurance, billing, collections, payment posting, refund, adjustment, and cashiering functions. In 2005, these costs amounted to 336 million dollars and account for 13 percent of total administrative costs.

Administrative Supplies and Services Costs: Cost of printing, postage, books, subscriptions, administrative and medical forms, stationery, bank processing fees and other administrative supplies and services. In 2005, these costs amounted to 255 million dollars and account for 10 percent of total administrative costs.

Information Technology Costs: Cost of practice-wide data processing, computer, telephone and telecommunications services. In 2005, these costs amounted to 362 million dollars and account for 14 percent of total administrative costs.

Medical Records Costs: Cost of maintaining records that meet the medical, administrative, legal, ethical, regulatory requirements of the medical practice. In 2005, these costs amounted to 362 million dollars and account for 14 percent of total administrative costs.

Contracted Support Staff Costs: Costs of all staff hired on a contract basis who are not employed by any of the legal entities included in the medical practice. In 2005, these costs amounted to 146 million dollars and account for 6 percent of total administrative costs.

Medical Secretaries and Transcribers Costs: Costs of staff who perform secretarial and transcription functions for the medical practice. In 2005, these costs amounted to 103 million dollars and account for 4 percent of total administrative costs.

Managed Care Administrative Support Staff Costs: In 2005, these costs amounted to 97 million dollars and accounted for 4 percent of the total administrative costs. Because managed care is relatively small in Washington State, we believe this amount is actually smaller than represented by adaptation of the western regional numbers used in this analysis.

Billing and Collection Purchased Services: Costs of purchased billing and collections services from an outside organization as opposed to hiring and directly conducting billing and collections activities. In 2005, these costs amounted to 84 million dollars and account for 3 percent of total administrative costs.

Other Administrative Support: Costs of staff who provide shipping and receiving, cafeteria, mailroom and laundry functions. In 2005, these costs amounted to 117 million dollars and account for 5 percent of total administrative costs.

Physician and Professional Staff (Billing and Insurance Related Activities): Costs of physicians and professional staff whose direct time is tracked and spent on billing and insurance related activities. In 2005, these costs amounted to 85 million dollars and account for 3 percent of total administrative costs. These costs do not include the indirect time or the portion of time that physicians routinely spend on billing and insurance related matters that are absorbed within the regular clinic activities.

Attachment 3 – Provider survey and summarized results:

Washington State Office of the Insurance Commissioner Health Care Administrative Expenses Survey
Response Status: Completes, percentages exclude N/A and do not knows
Filter: No filter applied, N/A's excluded
15-Oct-07

1. 1. Where is your primary medical community located?		
Greater Puget Sound; Everett-Seattle-Tacoma-Olympia-Bremerton	258	59%
Southwestern Washington; Vancouver-Kelso	22	5%
Inland Empire; Spokane and surrounding areas	44	10%
Central Washington; Omak-Wenatchee-Moses Lake-Ellensburg	12	3%
Southeastern Washington; Tri-cities, Yakima, Walla Walla	30	7%
Northwestern Washington; Bellingham-Islands-Skagit	29	7%
Peninsula and Washington coastal towns; Port Townsend, Port Angeles, Forks, West Port, Long Beach	16	4%
Statewide	3	1%
Other, please specify	24	5%
Total	438	100%

2. What type of health care organization do you represent? (Select all that apply)		
Physician organization	160	37%
Institutional or hospital based organization	24	5%
Allied health provider, e.g. chiropractor, physical therapy, counseling.	179	41%
Ancillary provider, e.g. imaging center, lab, pharmacy, or DME provider	24	5%
Other, please specify	77	18%

3. What position best describes your role within the organization?		
Owner, senior partner or physician leader	193	44%
Administrator or chief executive	65	15%
COO or senior operations executive	9	2%
CFO or finance professional	11	3%
Billing office staff or manager	127	29%
Other, please specify	32	7%
Total	437	100%

4. How many practitioners does your organization employ or contract with?		
1-2 practitioners	226	56%
3-6 practitioners	77	19%
7-15 practitioners	48	12%
15-50 practitioners	29	7%
50-200 practitioners	14	3%
greater than 200 practitioners	11	3%
None	34	n/a
Total	405	100%

5. If you are a facility, how many inpatient and/or outpatient beds do you manage?		
1-10 beds	24	51%
11-50 beds	11	23%
51-100 beds	1	2%
101-300 beds	6	13%
greater than 300 beds	5	11%
Total respondents with Beds	47	100%
no inpatient or outpatient beds	181	n/a
Total respondents without any Beds	181	149%

6. What is your approximate total annual revenue (received not billed)?		
Less than $50,000	81	19%
$50,001 - $100,000	72	17%
$100,001 - $500,000	97	23%
$500,001 - $1 million	42	10%
$1 million - $5 million	75	18%
$5 million - $10 million	17	4%
$10 million - $100 million	31	7%
greater than $100 million	13	3%
Total	428	100%

7. Approximately how much is spent on "overhead" and "administrative expense" together for the organization?		
Less than 40% of revenue	125	33%
41% to 50%	92	24%
51% to 60%	70	18%
61% to 70%	48	13%
Greater than 70% of revenue	46	12%
I don't know	47	n/a
Total	381	100%

8. How has your administrative expense trended over the past five to seven years?		
About the same as inflation, not a huge change	127	38%
Increased significantly greater than most other practice expenses and the costs have eaten into provider incomes and or caused significant fee increases	200	**60%**
Administrative expenses have trended lower than most other practice expenses	9	3%
I don't know	99	n/a
Total	336	100%

9. Which organizations are administratively easiest to do business with? Assess each type of organization with a "1" being the administratively easiest and a "5" being most difficult to do business with.

Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	Total 1s & 2s	Most Difficult	2	3	4	Easiest
Commercial insurers		42	57	150	117	68
	23%	10%	13%	35%	27%	16%
Medicaid		94	75	64	26	15
	62%	34%	27%	23%	9%	5%
Medicare		107	88	53	49	21
	61%	34%	28%	17%	15%	7%
UMP, or PEBB		22	45	91	77	53
	23%	8%	16%	32%	27%	18%
Workers Comp		72	75	83	60	23
	47%	23%	24%	27%	19%	7%
Other payers		22	45	146	100	49
	19%	6%	12%	40%	28%	14%

10. Please provide examples of why you ranked the hardest vs. the easiest to do business with.

376 Responses

11. What percentage of your claims are currently submitted electronically?

None	70	16%
1-10%	7	2%
11-30%	16	4%
31-60%	19	4%
61-80%	50	11%
81-90%	91	21%
91-98%	114	26%
99-100%	70	16%
Total	437	100%

63%
of organizations report that
80%+ of their claims volume are electro

12. What are the primary barriers to 100% electronic claims submission? Check all that apply.

Practice management software problems	94	23%
Clearinghouse problems with certain insurers or claim types	153	37%
Insurer is not easily accessible in an electronic means	162	39%
Prefer paper	48	12%
Claim requires attachments which can not be submitted with the electronic claim	223	53%
Other, please specify	79	19%

#1 barrier

13. What percentage of your eligibility and benefit questions are currently answered electronically?

None - use the phone not a computer	123	28%
1-20%	99	23%
21-40%	68	16%
41-60%	67	15%
61-80%	39	9%
81-90%	27	6%
91-100%	11	3%
Total	434	100%

9%
of respondents can get their eligibility & benefits answered online.

14. What are the barriers to increased electronic eligibility and benefit information?			
Practice management or other practice software or Internet problems	74	17%	
Clearinghouse problems with this type of information	51	12%	
Insurer information is not easily accessible in an electronic means	267	62%	#1 barrier
Prefer to call and discuss with the insurer, electronic means are already available	103	24%	
Other, please specify	140	33%	

15. For the following HIPPA Transactions, please rank where your organization is on use of the transactions.						
Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	**We use today**	**We plan to use**	**Need system changes**	**Waiting on Payers/Others**	**Don't Know**	
Eligibility check via browser	212	37	36	51	83	
	63%	11%	11%	15%	n/a	#2 most used function
Eligibility check via batch or automated process	76	28	64	44	202	
	36%	13%	30%	21%	n/a	
Detailed benefit information(eg deductables)	166	38	55	77	84	
	49%	11%	16%	23%	n/a	
Claims submission	328	16	23	9	43	
	87%	4%	6%	2%	n/a	#1 most used function
Claims status checking (via web browser or batch)	246	48	37	30	58	
	68%	13%	10%	8%	n/a	
Electronic remittance advice	177	52	52	36	101	
	56%	16%	16%	11%	n/a	#3 most used function
Point of Service collection of patient financial responsibility	151	33	51	50	129	
	53%	12%	18%	18%	n/a	
Real-time adjudication of medical claims	47	27	57	78	207	
	22%	13%	27%	37%	n/a	least used function

16. Of the following areas please assess the areas that are most dysfunctional and have the greatest opportunity for savings to your organization. Evaluate each area with a "5" being an area which has a major opportunity for administrative saving and a "1" being an area of little value to focus energy.								
Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	**Little value**	**2**	**3**	**4**	**Major Opportunity**	**Don't Know**		
Claims submission	86	72	73	41	122	24		
	22%	18%	19%	10%	31%	n/a	41%	#5
Posting claims payments and reconciliations	61	53	74	66	139	32		
	16%	13%	19%	17%	35%	n/a	52%	#4
Collection of patient responsibility (co-pays, deductibles, cost shares) from insured patients	55	57	58	74	163	19		
	14%	14%	14%	18%	40%	n/a	**58%**	**#3**
Collections from uninsured patients	86	41	58	66	134	39		
	22%	11%	15%	17%	35%	n/a	52%	#4
Eligibility verification and getting benefit information	28	40	73	100	171	16		
	7%	10%	18%	24%	42%	n/a	**66%**	**#2**
Getting authorization to provide care or submitting care related information, "insurer notifications"	28	35	63	77	186	35		
	7%	9%	16%	20%	48%	n/a	**68%**	**#1**
Providing credentialing applications and related information	51	45	85	60	151	33		
	13%	11%	22%	15%	39%	n/a	54%	#4
Contracting and contract management	40	48	91	70	115	56		
	11%	13%	25%	19%	32%	n/a	51%	#4
Completing forms, and phone calls for pharmacies and other ancillary providers	71	31	44	56	92	127		
	24%	11%	15%	19%	31%	n/a	50%	#4
Quality and or financial reporting	76	61	76	51	56	93		
	24%	19%	24%	16%	18%	n/a	33%	least valued

18. For the following questions please answer the degree to which you agree, with 1 indicating that you strongly agree to 5 indicating that you strongly disagree with the statement, (N/A for donâ€™t know).

Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	N/A	
The current amount of administrative expense and workload in my business is useful and necessary	51	80	52	105	136	4	
	12%	19%	12%	25%	32%	n/a	57% disagree
The health plan administrative policies are similar across health plan organizations	16	77	37	117	177	3	
	4%	18%	9%	28%	42%	n/a	69% disagree
The Medicaid Agency is seemingly more administratively efficient than the commercial entities	17	43	44	58	121	141	
	6%	15%	16%	20%	43%	n/a	63% disagree
The UMP, PEBB, and HCA Agencies are seemingly more administratively efficient than the commercial entities	28	61	107	67	40	123	
	9%	20%	35%	22%	13%	n/a	Mixed opinion
At the current rate of growth administrative cost, the system is going to have serious financial problems	133	107	78	31	34	40	
	35%	28%	20%	8%	9%	n/a	63% agree
I believe a health care system with a single government managed payer would eliminate most of the wasteful administrative costs	78	75	71	55	130	18	
	19%	18%	17%	13%	32%	n/a	Mixed opinion
My organization controls administrative expenses and we can make changes and improve the situation without the cooperation of other organizations, e.g. insurers	36	67	90	97	118	16	
	9%	16%	22%	24%	29%	n/a	53% disagree
I have found the work of the commercial insurers to be very helpful in reducing our administrative burdens; they are very open to our ideas to lowering the administrative requirements and costs	19	53	111	92	114	37	
	5%	14%	29%	24%	29%	n/a	53% disagree
My organization already conducts much of our administrative work in an efficient electronic method, we likely have little to gain with additional automation	31	87	110	133	55	12	
	7%	21%	26%	32%	13%	n/a	45% disagree
We use OneHealthPort's services which have simplified our administrative processes and saved us time	131	126	66	36	35	32	
	33%	32%	17%	9%	9%	n/a	65% agree
If we had a single website that provided the same information and electronic transactions in the same location for all payers it would significantly reduce our administrative expenses	221	101	52	22	23	9	
	53%	24%	12%	5%	5%	n/a	77% agree
Our organization has used the administrative simplification tools, e.g. HIPPA implementation guides, Washington Practitioner Application, and standard referral guides which are sponsored by the Washington Healthcare Forum and they have saved us considerable time and administrative expense	63	113	113	43	20	74	
	18%	32%	32%	12%	6%	n/a	50% agree

19. Please rate each of the following areas regarding the degree of attention and importance it could have in lowering your organization's administrative costs. (with 1 needing most attention and 5 not worth pursuing)

Top number is the count of respondents selecting the option. Bottom % is percent of the total respondents selecting the option.	Needs most attention	Needs attention	May need some attention	Does not need much attention	Not worth pursuing	N/A		
Investment in common "utility-like" IT systems to better connect the insurers (and other payers, TPAs) and the providers	76	134	105	19	29	56		
	21%	37%	29%	5%	8%	n/a	58%	#3
OIC and Payers restructure regulations and contract language to allow Point of Service collection of estimated patient financial responsibility.	99	150	83	17	17	52		
	27%	41%	23%	5%	5%	n/a	68%	#2
I could invest in work flow improvements in my practice setting if best practices were available to model changes that result in savings/efficiency.	51	122	115	46	36	48		
	14%	33%	31%	12%	10%	n/a	47%	#3
Common referral/notification processes and payment methods across all insurers and payers	207	133	50	13	8	13		
	50%	32%	12%	3%	2%	n/a	83%	#1
Medicaid policies and agency requirements need to be simplified and reduced where applicable	157	81	40	15	10	119		
	52%	27%	13%	5%	3%	n/a	79%	#1
UMP, PEBB, and HCA policies and agency requirements need to be simplified and reduced where applicable	77	95	85	41	12	109		
	25%	31%	27%	13%	4%	n/a	55%	#3
Insurers should establish a common set of claims adjudication policies and only deviate for well documented business reasons	219	114	46	12	13	14		
	54%	28%	11%	3%	3%	n/a	82%	#1
Payers should require less reporting and notification of care to be provided	191	107	78	21	12	16		
	47%	26%	19%	5%	3%	n/a	73%	#2
State should provide more oversight of the payment processes of the insurers	118	93	109	41	38	24		
	30%	23%	27%	10%	10%	n/a	53%	#3
A single common repository of credentialing, admitting and demographic data that all payers and hospitals must accept for their credentialing purposes	229	95	42	11	17	26		
	58%	24%	11%	3%	4%	n/a	82%	#1

Attachment 4 – Inventory of Washington Healthcare Forum's Administrative Simplification Accomplishments:

Washington Health Forum Administrative Simplification Innovation Area:	Comments and description:	Open Issues or potential enhancements
Claims Processing		
Submitting Supporting Documentation	Standardized form and basic process guidelines for submitting additional documentation for a claim.	Plans have differing policies on when supporting documentation is required.
Submitting Corrected Claims	Standardized form and basic process guidelines for submitting corrected claim information.	Plans have differing policies on whether to accept corrected claims electronically or require them on paper.
Following-Up on Processed Claims	Description of a basic process flow/key steps to establish how a provider and plan follow-up on a processed claim.	
Using Common Modifiers	Q&A about the different health plans policies and approaches to accepting modifiers on a claim.	Low adoption of the information that is available on line. Plans that do participate each have different policies regarding a specific modifier.
Anesthesia Coding & Billing CRNA Services	Standardized practice for how and when to use specific codes for billing Anesthesia services.	
Getting Claim Receipt and Status Information	Description of a basic process flow/key steps to establish how a provider and plan follow-up on the receipt of an electronic or paper claim.	
Conditions for Splitting Claims	Q&A and basic education about claim splitting practices. Online report to define which conditions apply to different plans.	Plans have differing policies on when and why they may choose to split a claim.
Quicker Resolution of Payment Responsibility for Injuries	Q&A and basic education about injury related claims. Online report and data to define specific policies of each participating insurer.	Plans have differing policies on how to bill and what to report on an injury related claim.

Incorporate Explanation of Benefits (EOB) Info on Electronic Claims	Basic education and processing guidelines for claims involving COB.	New state rules will be changing this guideline.
Resubmission of Claims Electronically	Basic policy statement and commitment by participating plans to accept claims resubmissions electronically.	
Clinical Notes Do Not Need to be Submitted for Emergency Room Visits	Basic policy statement and commitment by participating plans to NOT require supplemental notes in order to process ER claims.	
Patient Insurance Card Not Required	Basic policy statement and commitment by participating plans to NOT require a copy of a patient ID card in order to process a claim as long as appropriate identifying information is included in the claim.	
How Health Plans Handle Under Payments & Over Payments	Basic overview of why and how each plan processes under and over payments. Online report highlighting the practices and processes of participating plan.	Plans have differing policies and processes for managing under and over payments.
CPT Codes that will NO LONGER Automatically Pend a Claim for an Attachment	Updated listing of CPT codes that no longer routinely require claim attachments.	

Credentialing

Handbook for Practitioners' Staff	Guideline, Q&A, and aid to office staff preparing credentialing applications. Link to a commonly adopted credentialing application	Not all plans or hospitals accept the WPA and or some require additional information of different application formats.
Getting Confirmation that Credentialing Application was Received	Process description for how various plans notify receipt of the application	No similar process for hospitals and only addresses receipt of an application.
Effective Date for Claims Adjudication	Common policy statement describing the timeframes and process to complete the credentialing process for various types of providers.	Not all plans or hospitals accept the WPA or this process. Some require additional information or different application formats or apply different processes.

Referral and Prospective Review

One-Stop-Shop for Health Plans Processing Requirements & Contact Information	On-line report and information indicating the referral and notification requirements for each health plan and their various products.	Plans have differing payment policies and processing requirements for similar products.
Using Standard Referral Actions and CHITA Form	Q&A and detailed process descriptions for referral processing. Pointers on using a common form. Intended as an information resource to help reduce questions and provide clarity on existing policies.	Plans each have different expectations on when and why to require a referral. Other medical management requirements are not addressed.
Guideline for Women's Healthcare	Q&A and policy commitment regarding implementation of women self referral laws.	Slight variation on which conditions constitute a self referral.
Numeric Billing Codes on Referrals and Authorizations	Q&A and basic policy and processing guidelines on when to display numeric billing codes on referrals.	
Tolerance Period for Referral Effective Dates	Basic policy and background information on valid date ranges for a referral and any date tolerance that plans shall apply.	
Reduce Administrative Burden on PCP & Emergency Room	Basic policy & commitment to not require a referral for ER care. Implementation of state law.	
Guidelines for Requesting a Prospective Clinical-Medical Review	Commitment to use a standard clinical review form and basic Q&A and one stop information on how to fill it out.	Plans require different information on the form and use it differently under certain circumstances.

Attachment 5: UHIN Transaction Standards. As of 12/1/2007. Check UHIN website for more current standards.

	Name	Description	S=Stand. P=Spec.	State Approved
1	Anesthesia Standard	This standard provides rules for billing anesthesia claims in the State of Utah	S	v2.0 **08/13/2006**
2-A	UB-92 Form Locator Elements - Also see Specification 41A for flat file/print imageUB-92 Crosswalk	This Standard provides a free crosswalk between the UB-92 claim form and the institutional health care claim transaction (837). This crosswalk is for the use of the HIPAA institutional claim transaction within the State of Utah.	S	v2.0 08/13/2006
2-B	HCFA-1500 Box Elements - Also see Specification 41B for flat file/print image	This Standard provides a crosswalk between the HCFA-1500 claim form and the professional health care claim transaction (837). This crosswalk is for the use of the HIPAA professional claim transaction within the State of Utah.	S	v2.0 **08/13/2006**
2-D	Dental Form Locator Elements - See Specification 41D for flat file/print image	This Standard provides a crosswalk between the ADA 2000, 1994, 1990 claim forms and the dental health care claim transaction (837). This crosswalk is for use of the HIPAA dental claim transaction within the State of Utah.	S	v2.0 **08/13/2006**
3	837 Health Care Claim Standard	This Standard details the use of the HIPAA 837 implementation guides for UHIN members.	S	v2.1 **08/13/2006**
4	Provider Remittance Advice Standard	This Standard establishes the uniform standard for the electric remittance advice transaction used in the State of Utah.	S	v2.0 **08/13/2006**
4	Provider Remittance Advice - Flat File Specification	This specification details the flat file output from UHINT application for the benefit of provider systems.	P	
5	Trading Partner Number/UHIN Routing Number	This specification establishes a standard trading partner number and UHIN routing number practices for the UHIN network.	P	
8	Patient Identification Number	This standard establishes the SSN as the Utah standard for the patient's identification number.	S	v2.0 08/13/2006
9	Professional Common Edits	This standard establishes the common (UHIN) edits for professional claims submitted in the State	S	v2.0 **01/01/03**

		of Utah.		
9	Professional Common Edits Spreadsheet	This documents contains the professional common edits in a spread sheet format. This document is to be used in conjunction with the Professional Common Edits Standard.	S	v2.0 **01/01/03**
10	Facilities Common Edits	This standard establishes the common (UHIN) edits for facility (institutional) claims submitted in the State of Utah.	S	v2.0 **01/01/03**
10	Facilities Common Edits Spreadsheet	Thisdocument contains the facilities common edits in a spreadsheet format. This document is to be used in conjunction with the Facitities Common Edits Standard.	S	v2.0 **01/01/03**
11	834 - Medicaid Enrollment Standard	This standard establishes the use of the ASC X12 834 Enrollment transaction for Utah State Medicaid enrollments.	S	v2.0 04/12/03
12	HCFA 1500 Box 17 and 17A	This standard establishes a standard approach to reporting referring provider name and identifier number on the HCFA 1500 claim form.	S	v2.0 09/04/04
18	Functional Acknowledgement	This standard establishes the use of the ASC X12 997 transaction for use as a functional acknowledgement for HIPAA transactions in the State of Utah.	S	**v2.3** **07/08/06**
20	Front End Acknowledgement Standard	This standard establishes the use of the ASC X12 277 unsolicited transaction to use as a front-end acknowledgement for claim submission within the State of Utah. This standard also includes the UHIN Implementation Guide for the required transaction.	S	**v2.2** **08/03/05**
20	Front End Acknowledgement Specification	This is a supporting document that providesthe UHIN implementation of the 277FE This document is meant to be used in conjunction with Standard #20 Front End Acknowledgment Standard.	P	
20	Front End Acknowledgement Cross Walk	**This is a supporting document that provides a uniform method for the use of the STC codes within the 277FE. This document is meant to be used in conjunction with Standard #20 Front End Acknowledgment and Specification #20 Front End Acknowledgement .**	**P**	
22	Minimum Hardware Requirements	This specification establishes the minimum hardware requirements for connecting to the UHIN switch and using UHIN base line translators to connect to UHINet.	**P**	
23	Sender and Receiver Identification In the ISA and GS Segments	This specification establishes a standard use for various elements in the ISA and GS segments.	**P**	
24	Payer, Provider and Vendor	This standard defines the network connect	**P**	

	Network Requirements	requirements for payers, providers and vendors.		
26	Telehealth	This standard establishes standard billing practices for Telehealth claims in the State of Utah.	**S**	v2.1 09/13/2003
27	Coverage for Metabolic Dietary Products	This standard establishes standard billing practices for metabolic dietary products in the State of Utah.	**S**	v2.1 **09/14/2004**
28	Home Health	This standard establishes standard billing practices for Home Health and Home Infusion claims in the State of Utah.	**S**	v2.1 **06/12/2004**
30	Pain Management	This standard establishes a uniform method of submitting pain management claims/encounters, pre-authorizations and notifications.	**S**	v2.0 **01/01/03**
31	Eligibility Inquiry and Response Standard	This standard establishes a uniform method of eligibility inquiry and responses practices within the State of Utah .	**S**	v2.2
	Eligibility Inquiry Examples	This is a supporting document that provides a uniform method for the use of the eligibility transaction (270/271) for various levels of inquiry. This document is meant to be used in conjunction with Standard #31Eligibility Inquiry and Response Standard.		
	Eligibility Response Examples	This is a supporting document that provides a uniform method for the use of the eligibility transaction (270/271) for various levels of response . This document is meant to be used in conjunction with Standard #31Eligibility Inquiry and Response Standard.		
32	Benefits Enrollment and Maintenance Standard	This standard establishes the enrollment and maintenance process practices for the State of Utah .	**S**	v2.1 **12/06/2004**
33	**EDI Enrollment Requirements for Provider/Facilities**	**This specification establishes the expectations for new providers and facilities that join UHIN after March 2000.**	**P**	
34	**Psychiatric Day Treatment Standard**	**This standard establishes a uniform method of transacting psychiatric day treatment billing, prior authorization and referral practices.**	**S**	**v2.0** **01/01/03**
35	**Prior Authorization/ Referral Standard**	**This standard establishes the uniform method for the Prior Authorization/Referral transaction (278) in the State of Utah. This standard applies to both payers and providers**	**S**	**v2.0** **01/01/03**
36	**Claim Status Inquiry**	**This standard establishes the uniform method for the Claim Status transaction (276/277) in the State of Utah. This standard applies to both**	**S**	**v2.2** **07/8/2006**

		payers and providers and sets minimum requirements for each.		
37	**Individual Name**	**This standard establishes guidance for entering names into any Utah provider, payer or sponsor systems for patients, enrollees, as well as all other people associated with these records**	**S**	**v2.0 07/123/03**
38	**Security**	**This specification establishes standard security practices for UHINT and UHINet users.**	**P**	
39	**Testing and Certification**	**This specification establishes standard testing and certification practices for transition to the HIPAA compliant transactions.**	P	
41A	**Institutional Flat File (Part I)**	**In this specification Part I establishes a free flat file specification to be used by UHINT for institutional claim submission.**	**P**	
	Institutional Print Image (Part II)	**In this specification Part II establishes a specification for a free print image specification used by UHINT for institutional claim submission.**	**P**	
41B	**Professional Flat File (Part I)**	**In this specification Part I establishes a free flat file specification used by UHINT for professional claim submission.**	**P**	
	Professional Print Image (Part II)	**Part II establishes a free print image specification used by UHINT for professional claim submission's**		
41D	**Dental Flat File (Part I)**	**In this specification Part I details the flat file technical specifications used by UHINT for dental claim submission.**	**P**	
	Print Image (Part II)	**Part II establishes a free print image specification that can be used by UHINT for dental claim submission.**		
43	**Eligibility Inquiry Flat File Specification**	**This specification details the UHINT flat file for eligibility transactions for those wishing to use in a batch mode for eligibility transactions.**	**P**	
44	**Claim Status Flat File Specification**	**This specification provides the a flat file technical specifications for those whishing to use UHINT in a batch mode claim status transactions.**	**P**	
45	**Error Report**	**This specification #45 may be used by agreeing trading partners to communicate semantic and implementation guide level syntax errors at a minimum. This guide is not intended to replace or be used in lieu of the 277FE. Medicare will be using this specification to report semantic, implementation syntax, content errors and accepted Claim counts in conjunction with the 997.**	**P**	

46	Unknown Values	This UHIN Standard is intended to provide rules for the use of common data values that can be used within the HIPAA transactions when a required data element is not known by the provider, payer or sponsor for patients, enrollees, as well as all other people associated with these transactions.	S	v2.0 06/14/04
47	Change Mangement	This UHIN Specification is intended to provide a process for UHIN members to follow when changes to UHIN services are requested or implemented.	P	
48	834 Enrollment and Response	This specification supplies the technical specifications for Employers that intend to use UHINT to send 834 Enrollment files. This specification also has the Response Implmentation Guide that payers can use to report enrollment transaction errors to the Employer.	P	
49	Provider Data Exchange	This specification supplies the specification for those entities that intend to use UHINspeedi for exchanging enrollment/crednetialing data through UHINet.	P	
50	Coordiantion of Benefits	This UHIN Standard is intended to streamline the coordination of benefits process between payers and providers. The over all goal of this standard is to define the miminm data to be exchanged for the coordination of benefts.	S	
51	National Provider Identifier	This UHIN Standard is intended to assist with the transition from legacy provider numbers to the NPI for pauer and providers	S	v2.0
52	Chief Complaint	This Specification details the technical requriments for entities to report Chief Complatint Data to the Department of Health.	P	
53	HL7 Header and Trailer Specification	This Specification details the technical requriments for header and trailer segemetns for HL7 messages.	P	
54	HL7 Acknowledgement and Error Status Specification	This Specification details the technical requriments of the HL7 Laboratory Result v2.2	P	

55	HL7 Laboratory Results Specification	This Specification details the technical requriments for entities to report Chief Complatint Data to the Department of Health.	P	
56	Professionsl Claim Form (CMS1500)	This documetn details the new CMS 1500 Paper Claim Form	S	
57	Institutional Claim Form (UB04)	This documetn details the new UB04 Paper Form	S	
58	Electronic Funds Transfer and Automated Clearing House	This documetn details the crosswalk between the ACH and provides guidence for UHIN members on the EFT and ACH tranascations.	P	
59	Acknwledgements	This documetn details the appropriate acknowledgements for various transactions/messages	P	
n/a	Route Server Connection Document	This document explains how to connect to UHINet as a Route Server	P	
n/a	Directly Linked Trading Partner Doc Router Client Connection Document	This document explains how to connect to UHINet as a Provider. This document explains how to connect to UHINet as a Router Client (DRAFT).	P	
n/a	UHINT/UHINet Release Notes	Release notes for v1932 relase dated 8/02		
n/a	UHINT/UHINet Task List	These documents provide the remaining tasks for completing UHINT and UHINet system in two different view, Date Sort and Subject Matter Sort		